Tuesday, 22 September 2020

(10.00 am)

SIR BRIAN LANGSTAFF: The last six months will have been difficult for all of us, especially participants. We meet under the shadow of COVID still. A large proportion of those who were given blood or blood products and as a result were infected or put at risk of deadly disease are now from the older sections of society, and that itself, let alone the continuing effects or after effects of their diseases, or of the treatments they and their spouses, families and friends have endured, is enough to make them particularly careful for their safety. Yet so many have registered to come in person to these hearings already timetabled that for a number of those hearings the places are fully subscribed.

I'm sorry that we can't accommodate more. You will understand why that is. We, of all people, have to take care to reduce the risks. I'm sorry if this seems restrictive but I don't want to dwell on my regrets, though they are at least tempered by knowing that we have been able to find as much space as we have in the hearing room for those members of the public most affected by what took place and who particularly wanted to be here.

What I would like to focus on first is the fact that you have chosen to come. No-one could have complained if you had chosen to stay home. Indeed, many have had little choice but to do just that. Distance alone may prevent attendance.

Those who are here remotely are very welcome but for those of you who have come in person, your being here in the numbers that you are, despite the perils of the pandemic, tells a story. It emphasises how important the issues are to you. It show the value of these hearings. It says you have chosen to be here rather than keeping strictly to yourselves safely at home, because you see this as really valuable.

The decision to come or not is personal. It's a courageous decision, not for everyone to make. Courageous? "Courage" is, I think, the right word to use, and I'd like to pay tribute to you for having had the courage to come here in present times.

Just as I acknowledge your courage in being here, I would like to acknowledge in advance the courage of those witnesses who have agreed to come in person here from whom we will hear in the autumn months and early next year and today. Many are old. Age, fading memories, and, for some I suspect, a sense that they may feel isolated in the witness chair, all

mean that we should all the more respect and value their willingness to give evidence under the current challenging circumstances.

They too may feel threatened by the keen edge of risk but also recognise the importance of being here to deliver their testimony. Treating every witness with respect is one of the six key principles fundamental to this Inquiry. We have listened with deep respect to those who had the bravery to describe some of their most intimate feelings, not just to friends but to strangers.

You will have heard some say things you would not necessarily agree with but you have respected their right to say them. I believe that you would wish to pay similar respect to the clinicians and others from whom we are about to hear. You may well hear some of them say things you do not and will not agree with but I trust that you will respect their right too to say them.

It is a central principle of this Inquiry that we do that. Many participants in the Inquiry who followed it closely would have been here in person but have to be present remotely, and everyone understands why they cannot be here. There will be witnesses who also cannot, for good reason, be here in person and

they will have to give their evidence remotely. Now, when that happens, those of you who are here will see counsel in person, you will see me here in person, you will see the witness on a large screen above the witness chair, and it will come as close as we can get to their being here in person, being physically present.

Please don't take it against them that they are not here in person but accept my assurance that there is in each case a good reason for it.

During our earlier hearings, there have been occasions when something has been said which is not to be repeated. For instance, where an anonymous witness has unintentionally described events in a way which indicated what their name was. To deal with this, there has been a time lag on the simultaneous transmission, to allow the technicians to ensure that the public listening remotely did not hear it, did not hear what they shouldn't have heard, and it has never appeared in any transcript.

However, I am determined that arrangements should be made for those who would have been here but simply can't be because of COVID, and that those arrangements should be replicate as closely as is possible what would have been the position if they had

been. So those who have given an undertaking of confidentiality can access a live stream without a time lag. They will hear what is said as it is said and see what is to be seen even though it may later be redacted from YouTube or the transcript in order to protect confidentiality.

This privilege has necessarily to be subject to some restrictions, and so just as from time to time in earlier hearings I made an order which made it against the law to break that confidentiality, I shall make one now. It reads like this:

It is ordered that (1) unless express permission is given by the chair of the Inquiry (me) or the solicitor to the Inquiry acting on my behalf, evidence given to the Inquiry in oral hearings and broadcast by live feed accessible on the Zoom platform must be kept confidential and must not be disclosed or published in any form unless and until such evidence is broadcast on the time-delayed YouTube platform and/or a transcript published on the Inquiry's website.

Any information that is redacted from the time-delayed feed and/or the transcript of proceedings must not be repeated, disclosed, or duplicated to any -- any -- third party.

This order remains in force for the duration of

the Inquiry and at all times thereafter unless ordered, and I may vary or revoke the order by making a further order during the course of the Inquiry.

Now, that's an order but can I also make some requests of you. First, those of you who have been here before will know that others do not wish anything to be done which might affect their legitimate desires for anonymity. The press will take care not to film or photograph anyone without first getting their permission. Please also be careful that if you do take photographs or film yourself, make sure that you don't inadvertently capture anyone who does not want to be photoed or filmed, please.

Secondly, we have a responsibility not to harm others. It will be a great pity -- well, actually more than that, it would be a great disaster if because we weren't scrupulous about social distancing, about "Hands, Face, Space", and sticking to our pre-allocated seats, that we happen to be the cause of someone else's infection. Then our contacts might have to self-isolate. It could lead to the Inquiry staff having to self-isolate if they have been too close to you for too long, or even to counsel to the Inquiry or to me being put out of action.

I said "we" because what applies to you applies

to my staff, applies to counsel and to me. I will miss not being free to meet and chat with many of you over the course of the day. You'll understand why.

I will be staying apart every evening, as will Ms Richards. I would ask all of those of you coming to Fleetbank to be mindful of others and careful of your own social distancing, especially if you are away from home for the days you've booked to come. I don't ask you to do anything that I would not expect to do myself.

In addition to paying tribute to your collective courage in being here and recognising that of the witnesses yet to come, the last six months have made me reflect on the resilience shown by so many. From what I have seen, it appears that the legal representatives of participants have continued their work despite the challenges. From what I know firsthand, the Inquiry's own staff and counsel team have continued their work relentlessly. It may have seemed to you as if nothing much was happening or was happening. There is more to an inquiry than public hearings in the full glare of publicity. They may have been working from home but they have been working full on. Their collective resilience has been and will yet be vital in ensuring that this Inquiry is

able to reaffirm its principle of being as quick as reasonable thoroughness permits.

Finally, let me say this: some who are listening may have wondered how important this Inquiry really is. Well, lest anyone doubt the importance of this inquiry continuing as best it can, and the potential importance of any recommendations it may make as to the future, they may wish to reflect on this.

As of 1 pm yesterday, COVID was reported to have caused 31 million infections and just over 960,000 deaths worldwide. That is a horrifyingly huge number.

Yet our experts have already told us that as at today, it is estimated that more than double that number are already infected and living with hepatitis C, 71 million worldwide. As for hepatitis B, over three times more are positive. 39 million have died from hepatitis B infection, a figure not only higher than the number of deaths from COVID so far but higher than the number of infections from COVID so far. And 36.9 million people, more people, worldwide currently live with HIV infection and those numbers too are huge and horrifying.

Now, of course, the Inquiry is dealing with the

transmission of hepatitis and HIV viruses through blood or blood derivatives. That is by no means the only cause of transmission of such viruses. What we are concerned about is this country, by which I mean the whole UK alone, not the whole world. The infections occurred over several years rather than several months and none was a respiratory infection. Of course, we are concerned with whether preventable human error played a part. I'm not trying to minimise at all the importance of COVID. We all have to take it very seriously indeed but, against the backdrop of such worldwide figures, no-one should be in any doubt that this Inquiry is dealing with other viruses also capable of doing serious, lasting damage to society. Those diseases should not be minimised either. They had a significant impact in this country. No-one should underestimate their potential severity, no-one should undervalue the hurt they have caused and no-one should doubt the importance of what this Inquiry is about.

Ms Richards, that's all I want to say at the moment. We're now in a position to hear from Lord Owen.

Lord Owen, would you come forward, please.

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LORD DAVID OWEN (sworn)

Questioned by MS RICHARDS

MS RICHARDS: Lord Owen, I'm going to start by asking you a handful of questions about your career and background. You qualified as a doctor in the early 1960s and then became MP for Plymouth in 1966. You remained a Plymouth MP I think until 1992; is that right?

A. That's right, when I didn't fight the election in 1992.

Q. And at that point you became a Life Peer and you sat and continue to sit in the House of Lords?

A. Yes. I went off to the Balkans for nearly two and a half years.

Q. Now, the questions that I'm going to ask you today are primarily concerned with the time that you were a minister in the Department of Health. And just so that we can understand the dates, in March 1974, you became the Parliamentary Under-Secretary of State for Health?

A. *(The witness nodded)*

Q. And then on 26 July 1974 you were appointed as Minister of State for Health. Could you just explain briefly the difference between those two appointments?

A. Well, the Ministry of Health in those days was

a massive ministry, and it was called the Department for Health and Social Security. Just to lighten the mood, we used to call it the department of stealth and total obscurity. And Barbara Castle was the overall Secretary of State, and she was very involved in pensions for reform and wanting to -- and I was initially appointed as a Parliamentary under-secretary because the Prime Minister had run out of minister state positions but he said that as soon as he legislated he would increase it. So I was made Minister of State but I was treated really as a Minister of State right from the start because I was the main relationship with the medical profession, the nursing profession and the patients.

Q. Just so that we can place the political context, you were part of the newly formed Labour Government after the election in February 1974?

A. Yes, sir.

Q. As you've indicated, Barbara Castle became Secretary of State for Health. She replaced Keith Joseph, and the Prime Minister was Harold Wilson, replacing Edward Heath?

A. Yes.

Q. And I understand that there were two posts of Minister of State for Health. The other at the time I think

was Brian O'Malley?

A. Well, he was called that but he was Minister of State in the Department of Health and Social Security, and his sole responsibility was social security and my sole responsibilities were health.

Q. I just wanted to ask you a little, if I may, about the structure and organisation and dynamics of the Department in those two/two and a half years that you were there.

First of all, in terms of the Secretary of State for Health at the time, I think until April '76 Barbara Castle, what interest or role did she take in issues relating to blood and blood products and blood safety?

A. Well, we met every week, ministers, with her and so there were -- the Minister for the Disabled was there, Alf Morris, and her Private Parliamentary Secretary, Jack Ashley, was there, who was actually deaf. So there was a sort of quite a lot of emphasis on people who were handicapped and serving actually in our own Ministry. Then Brian O'Malley would be there to deal with social security and her own Private Parliamentary Secretary in the House of Commons, Jack Straw, who then later went on to have a distinguished career, was there. We discussed almost everything that was

political, going to come up in the House of Commons and the overall manifesto, what we were dealing with that, and these were informal discussions. But that was the occasion in which you would keep her abreast of what she was well aware was a difficult and controversial issue, which was blood contamination and the whole question of treatment of haemophilia. So she was, I would have said, fairly continuously kept in touch. As a consequence, she was quite happy to delegate practically all the decision-making to me.

Q. And then in terms of the --

A. Sorry, I should add, she also had -- Professor Abel-Smith was a political adviser to her, but he was also a very experienced and knowledgeable academic in the Health Service and Social Services.

Q. And then in terms of the role of the Chief Medical Officer, who I think again at the time we're talking about was Dr Yellowlees, what discussions or dealings, if any, do you recall having with him, again on the issue of blood safety, blood products or treatment for haemophilia?

A. I discussed some of the sensitive issues with him directly but he had a very good deputy, Reid, Professor Reid, who was mainly involved with blood transfusion services. So I saw -- he would be more or

less there at any big meeting I called on the subject. Henry Yellowlees would be kept in touch with him by him. We would discuss -- he'd sort of come in with a list of issues, I should think more or less every week really, to just discuss informally with me what was happening, and then sometimes this issue would come up at that stage.

But he kept a close watch on it and he was the one who issued instructions to doctors, a so-called "Dear Doctor" letter from the Chief Medical Officer, and that, from time to time, would deal with this issue -- sometimes only devoted to this issue to give guidance.

It's pretty important for people to understand that it's an accident of history that I'm a medical doctor. I'm a politician first and foremost, in that role, and I have to be very careful not to use my medical knowledge to try to overturn decisions which are really about clinical expertise and advice. When I left the department, he wrote to me a rather nice letter and said he was horrified at the thought of having a doctor in my position but fortunately there were no problems.

I had to be very careful about that. And I wanted to be because the clinical freedom for the

medical profession is a very, very important aspect of being a doctor, and the personal relationship between the doctor and the individual, the one-on-one relationship, is, I believe, the very essence of the National Health Service. And it's usually done through your family doctor but if you were referred to a consultant, then that relationship transfers in a hospital setting to the consultant.

I know we're all living in an age where everything is going to be done by computer and everything like this and all the conversations are going to be done on the telephone and everything like that. That is the response, and a necessary response to COVID and the situation of a pandemic. But I do hope we don't reverse out of the important one-on-one private relationship between the clinician and the patient. And in the case of young children, and a lot of haemophiliacs were presenting as young children, then of course it's the parents.

Q. So in terms of the giving of any advice or guidance to the medical profession, that would essentially, from your perspective, have been the Chief Medical Officer's role?

A. Yes, entirely, and the hierarchy underneath him, going down through Regional Medical Officers of health and

everything like that.

Indeed, there was in my day a structure in the Ministry of Health which had been introduced by Sir George Godber, one of the great Chief Medical Officers of Health that we have ever had, and this was a dual hierarchy, it was called, and no big decisions were ever taken that weren't taken by two individuals. One would be a representative of the Civil Service within the Department and the other would be a representative of the medical profession.

It's one of, I think, the issues which may be, sir, you and your Inquiry will wish to address, that the dual hierarchy system was effectively abandoned in 1980 when the then Prime Minister queried why there were all these doctors in the Ministry of Health. Why weren't they out seeing patients? Why aren't they doing that?

Well, these are doctors with a public health interest. The then Chief Medical Officer came in from the Department as a paediatrician, Professor Acheson, and he seemed quite happy to shed this. The Civil Service were only too happy to take complete control of the Department.

I think it has been one of the factors why some pretty odd decisions have been taken by the Department

of Health over the last two or three decades, that it has been deprived. And I have drawn attention in my witness statement to an academic study by Sally Sheard of Liverpool University, now a professor of social science there, which does draw attention to this.

To some extent, this was dealt with, and it can be read about in Lord Crisp's evidence, when he was the chief civil servant in the Department, and he introduced what was called SARS, and you brought in people of experience and medicine and surgery, into being -- advising the Department and that to some extent dealt with the issue of dual hierarchy.

But the Treasury, of course, always wanted it to be run entirely by the Civil Service. They disliked the idea that the Department of Health was different and that there was input from the medical profession. But I personally think this has been a very, very serious error and it has damaged health decision-making overall over the last 30 years.

Q. In terms of the civil servants and doctors with whom you were dealing within the Ministry, can you recall and identify for us by name the senior individuals with whom you were dealing on the issues of blood safety and blood products?

A. Well, as I say, Professor Reid. The deputy CMO is

really the main one. Sometimes people came from the regional blood transfusion services but my relationship was pretty much a secondary one, you know. I issued a decision within the departmental structure which had doctors and civil servants there. Of course the pretty important civil servant was the one with relationships with the Treasury explaining how to cope with it.

Remember, the Treasury in those days, and I think to some extent still exists, used to have a year-by-year budget. One of the things that horrified me about it was the difficulty of taking long-terms decisions and, you know, five-year programmes. But the overall Treasury involvement in what decisions were made was pretty intense and you had to live within your budget.

One of the problems was it was sometimes easier to get revenue than capital and, you know, in order to reduce revenue you need sometimes to put down capital and you only get the return back in revenue three, four, five, seven years' time on. That was again a problem in the decision-making structure. It's to some extent been changed by successive re-organisations which the Health Service has been subjected to.

But I would stress this: it was a pleasure to work with these people. They were dedicated to the National Health Service. They were ready to accept political decisions. In one of the papers that is before you, a paper right at the start, was effectively warning me this is going to be costly and are you prepared to pay for it, and are you prepared to pay a price elsewhere, which could be a sign -- indeed it was a sign -- that some people in the department thought there were other priorities, acute medicine, acute surgery. They were all bearing on you every hour of the day. But I took the decision and that's where it was important that we provided for the regional health authorities for self-sufficiency half a million pounds -- not much actually in terms of a massive budget that I was dealing with day by day, but it indicated to the regional transfusions that this was a central policy that we were going for self-sufficiency and it made it easier to grease the wheels, if you like, of the decision-making process.

Many of the regional health authorities wanted their own independence and there is a scathing article in the British Editorial -- in the British -- the BMJ, the British Medical Journal, I think in 1980 written by the Scottish, head of the Scottish Blood

Transfusion Service. In those days Scotland was all part of the UK but they had their separate secretary of state answerable for health policy -- very, very critical of the blood transfusion service -- and basically questioning in that '80 journal whether the Government really were committed to self-sufficiency, so flagging up that issue very much. It's an extremely important article, actually.

Q. Which you have exhibited I think to your statement.

A. It's in my evidence, yes.

Q. Just returning to the officials and whether civil servants or medical within the Department of Health, in your evidence to the Archer Inquiry you suggested there had been a degree of resistance to the idea of the policy that was introduced but then you went on in your evidence to say that once you had made the policy decision, civil servants and others within the department were not obstructive and implemented your will.

Is that correct analysis of your evidence?

A. Absolutely. That was the memo I referred to, which they quite rightly drew to my attention. You can't have your cake and eat it, despite people believing you can, you can't. You have to choose in a big spending department like this, with any number of

priorities coming at you, and it's always easy to find money for the big issues, the dramatic operations, the new cancer cure and everything like that and your job is to try to make sure that the money is spent on proper priorities, not always the ones that are popular or things like that, sometimes the minority cases.

When we were starting, you know, a treatment for haemophilia had only just come through, Factor VIII, and we should remember that we're really in an experimental area all this time, gradually finding out what's right to be done.

But I had no doubt whatever. I was *[redacted]* I was going every week or sometimes more often than that to Great Ormond Street and I was seeing, day by day -- people should not -- I'm sure you have had a lot of evidence on it, I don't want to press it too much, but this haemophilia, the bleed into the joints of a young child are crippling, and you could see it in Great Ormond Street out-patient clinic. I was waiting there in the queue as Minister of Health *[redacted]* and you would see a child seriously crippled in the legs or the arms because of a bleed into the joint. So we're not dealing with a minor issue.

Q. Your interest in the blood supply and blood safety, in fact, pre-dated your appointment as Minister because you'd read and written a review of a book by Richard Titmuss, *The Gift Relationship*?

A. Well, it is a wonderful book and I actually believe -- any of you who're involved with this Inquiry, I recommend you read it because it's absolutely modern, up-to-date. All the stuff is still there.

This is a professor at LSE on social -- and he was trying to write a book about altruism, and he chose as a demonstration of altruism the simple arrangement in the United Kingdom that you walked in voluntarily into a blood transfusion clinic or a mobile van, you gave blood, you were asked a few questions. A very important question that was starting to be asked was, "Have you ever had jaundice? Have you ever been yellow?" Which was a question which would indicate whether or not you had had hepatitis. We didn't know how to find hepatitis, let alone treat it very well, at that time. And this was the sort of question. And he draws attention to the fact that if you're going in there and you are not paid, you volunteered, all you get afterwards is a cup of tea, you're likely to answer that question truthfully. And if your answer is yes, people said

you can still have your cup of tea but I'm afraid you can't give blood.

Now, the problem of the donor when the donor has been paid and is off Skid Row or is a drug addict or anything like that, is they are not going to answer that question.

Now, I went to Greece when I was a young medical student and you could give blood and earn some Drachma, so we went off and gave blood, and that was when I first experienced, in Greece, they asked that question, carefully, and we answered it. So I actually had that experience. So when I read about this in Titmuss' book it was all for real, and it was a sign of -- his purpose was to remind people that not everything is valued by the money that you're given. Sometimes a voluntary gift can bring health to a child, in this case perhaps with haemophilia, but its operations and everything like that.

I think we've actually -- we were at danger of taking the Blood Transfusion Service for granted actually a little at that stage and one of the first things that happened with the decision to go to self-sufficiency is the number of people volunteering increase and I think we should never forget it and that was when I first realised how dangerous it was to

rely on blood coming in from abroad, from people who were giving their blood for money, were often giving it too frequently, and lying about it and within that community of blood-givers they soon sack out that a decision to say that you have been yellow means that you are taken off the thing and no money, so they don't answer the question truthfully.

All this with academic precision, but also beautiful writing, is explained in it. So I reviewed it for the New Statesman in I think 1970, so even before I became Minister of Health I had taken a view on blood transfusions and I had taken it when I was a young doctor, when I was a medical student.

Q. One of the chapters of the Titmuss book entitled "Is the gift a good one" looks at this very issue of the risk of transmission of hepatitis?

A. Yes.

Q. Henry, can we just perhaps put the chapter up on the screen. You should have it at HSOC0019917.

I am not sure if you have the whole book or just chapter 8. Can we go to page 142.

So we can see here and I'll only refer to a couple of extracts, Lord Owen, at the beginning of the second paragraph:

"In the United States, Britain and other modern

societies the most dangerous of these hazards [and those are hazards resulting from the use of blood and blood products] is serum hepatitis. It is becoming a major public health problem throughout the world."

Then, Henry, if you could just go to the last page of the chapter, which is page 157, we can see under (iv), four lines down, there's reference to three broad conclusions and then there's this, if you could highlight the sentence beginning "The first is that", please, Henry:

"The first is that a private market in blood entails much greater risks to the recipient of disease, chronic disability and death."

So having read and absorbed and reviewed Titmuss as you did in 1970 you were in no doubt as to the risks from blood and blood products?

A. Absolutely. I don't believe that any doctor in the country had not become aware of it. It was first used in 1972, the commercial human Factor VIII was used in this country, and that was because we were not getting enough from our own Blood Transfusion Service, so there was never any secrecy about this.

I mean, this is a whole question of clinical freedom and this whole vexed issue about how much to say to a patient. Firstly, we've got to understand

that the climate has changed a great deal. I mean, now we talk about rights of patients, we talk about the necessity to ensure that everybody knows about all the side effects of almost any drug that you give to people, and that they are put in a decision-making position as patients, making an informed choice.

Now, one of, of course, the problems is that when you are dealing with a child that child can't make those decisions so the patient, for the purposes of the doctor making with the family the decision. So quite often the young child will not know about this, either the conversation is above their head, though held with them in the same room, or sometimes it will be held separately with their parents and they go through this vexed and agonising choice about what is being told.

Now, that's very difficult but throughout this period you will find evidence coming back before doctors bodies, either through departmental bodies, Safety of Drug Commissions or special groups of doctors connected with haemophilia or the blood groups and many of the people in the department are writing papers and advices. I mean Rosemary Biggs, Dr Maycock, I would see them regularly, and they have been making very clear statements about what options

were available, and one of them was that cryoprecipitates were much less dangerous than AHG concentrate, but AHG concentrate allowed a patient to be treated in their home and AHG concentrate meant that somebody, the parents could be taught how to inject it and they could inject it as soon as the fall had taken place, and if they injected as soon as the fall within minutes the chances of the joint being damaged with blood pouring into the joint and leaving permanent damage were much less.

So the medical profession was saying overall from the start of their research cryoprecipitate is the safest, but that involves blood in bags and being done, could be done at home but very difficult and much more likely to have to go into hospital for it, and cryoprecipitate therefore was safer but all the time there was this pressure for home use.

Cryoprecipitate could be given in an operating theatre environment, for example, easily and would be used and for a long time cryoprecipitate was considerable -- it was only in '74 I think we went up to 13 per cent of AHG concentrate and mainly coming, not always exclusively, but mainly starting to come from abroad because we were short.

Well, I didn't sit on any of these committees,

and nor should I have done but I don't envy them their choices that they were having to make as doctors, and you all may -- you, Mr Chairman, and your Inquiry and others -- may have already come to a decision about this that the wrong decisions were taken. But I wouldn't like to be second judging. All I can say is, I read those papers, I read the choices, I saw it day by day, and it was not in my power, really, certainly not in my -- I think I would say it was not really in my power. It would have been an abuse of my power to have interfered with that decision-making.

But I in all conscience don't think I do disagree with the decision-making. What I did feel was that you've got to stop this blood coming in from, mainly, America, not totally involved in America, and you've got to make it -- because, after all, we know about hepatitis -- not a lot, but we knew about it -- but how many other drugs were coming down this -- infection was coming down?

And of course I didn't have to live with it but the HIV was already there, and we were infecting children and adult haemophiliacs with HIV. AIDS was the disease, HIV was the virus. And then came other viruses, like Creutzfeldt-Jakob disease, which is with us now. I mean, do we all realise that in 1998 the

governments of the day, because of the risk of what is popularly called "mad cow disease", stopped all production from British blood of haemoglobulins, the concentrates.

So, as a result, we do not have an immunoglobulin in production in this country from British blood. And we don't actually have it because the Government has not and other governments around the world have not yet moved that. We will transfuse the blood of a patient who has had COVID but we will not transfuse, if you like, the equivalent of Factor VIII, the concentrate of it, because of it.

So this Inquiry is looking back, but in looking back we were looking forward. You were looking forward to how we deal with the current situation of producing immunoglobulin. We have a company called BPL in this country well able to do it. It's actually safer to use the fractionation than use a transfusion of actual blood, because you can take out lots of other factors. But we're still not using it in COVID at this moment. And I put in a supplementary submission to the Inquiry about that. I know you don't want to be overburdened by it, but this is not a historic inquiry. This is not, as the Chairman said in the early introduction, and the numbers and

everything like this, this is a very relevant, hugely difficult medical decision, and I personally conclude from all of this that we've got to stop relying on governments to make awards or judgments of liability and inadequate payments after years of pressure in Parliament and all this and go for the New Zealand system, with no fault compensation, and take it out of law courts and take it out of all this confrontational system and accept that in healthcare we sometimes damage patients. Not willingly, not wantingly, sometimes out of ignorance, sometimes out of, in this case, deliberate decision.

I'm sorry to go on so much about this but these are huge, complex issues and it's so easy to point the finger and to say, "That was wrong" or "That was wrong". You are faced with a parent absolutely longing to do more for their child, and they hear in The Haemophilia Society or friends or people in the same treatment in hospital and they say, "Well, you know, this new treatment is very much better, we have it all at home", they want it at home, and then they want it prophylactically, to stop it paining. So it's not surprising the demand was increasing all this time but also all the time the risk was increasing.

Q. Your time as minister coincided with a growing

awareness of the existence of what was then called non-A non-B hepatitis?

A. Yes.

Q. A number of years later identified as hepatitis C. Can you recall whether that was drawn to your attention or whether there were any discussions specifically within the department about non-A non-B hepatitis at this time?

A. Well, a huge amount of research was being done and papers were being published during this time about it, and we were gradually getting to know more about hepatitis and -- as the figures were done. I mean, worldwide, it was a huge, huge problem.

Q. What was --

A. But there was a globulin that you could inject yourself with. I suspect many people who -- in this audience or elsewhere who travelled abroad were told by their doctor, "We can give you an injection, which only lasts about two to three months, but if you are going to an area where hepatitis is virtually a pandemic we advise you to have it and that will give you cover from it". So all the time that we were doing research on Factor VIII, we were also doing research on other immunoglobulins. And as I say, we ought to be using it for COVID.

Q. Were you advised or do you recall any discussions with the Chief Medical Officer or within the department about the relationship between the size of donor pools and the risks of hepatitis?

A. Yes, and there is no doubt. I mean, Rosemary Biggs wrote a book about all of this, and she posed the question: could we use, for the people who have only minor haemophilia, not too frequent bleeds, bleeding, and not many bleeding in the joints, we'd only give cryoprecipitate? Or small donors? Because as your audience will have probably already had explained to them, that the bigger the pool of donors, the greater the risk, because one donation in a thousand will contaminate. So if you come down to a donor pool of, say, 100, the chances are much -- well, they're 10 per cent less.

So, I mean, all these were being discussed and tried to be applied but it is difficult to decide. A doctor's trying to do the best for their patient. They explain it to the parents of the child and they may say, "Well, what's the treatment that's least likely to have any bleed?" And he has to say or she says, "This one, but there are chances of ..."

Now, I don't know how much was being discussed. You know, some doctors weren't open enough about it,

let's face it. All I decided -- and that was a political decision -- we will have no secrecy about this in the department, we will have no secrecy about this in letters we write to Members of Parliament. At one time I actually say we must put more information out to Members of Parliament. They must face up to these risks because they were getting a lot of questions and then when I was asked whether I would do the World in Action programme I said yes, knowing full well this whole issue would be exposed.

Of course, this was a very popular programme and a good programme and in two series maybe you will discuss this and show some things about it but this was trying to bring it out into the wider public domain and so we mustn't be afraid of this. These are difficult choices and, as far as possible, we should try and tell patients about it. As I say, you know, nurses were very good on this. Nurses are better at this than doctors. Doctors in my day were rather hierarchical and a bit sort of keeping some information to themselves, nurses were much more open and probably mainly because they were women and they were seeing it. So they wanted more discussion about this and I think that gradually the influence of nurses and more and more of the treatment began to be

done by nurses not by doctors because they would get specialised in this form of treatment and they would talk to the patients and they would explain it more.

But -- I know this and many people have said to me and families, you know, because they come and talk to me about this, compensation and things like that, and they say, "But I was never told". Maybe they weren't but you can be told about something and shut it out. That's again human nature. You face up to the choice, you make the decision and you hope and pray that it won't be -- you won't be the one. That's another instinctive feeling of people, you will somehow be the lucky one.

Q. We will be hearing from a number of clinicians over the coming months who we will ask about that.

Lord Owen, what I would like to do next is look at a handful of documents that pre-date your appointment to the Department of Health so that we can get some sense of what was or was not being done in relation to self-sufficiency before you arrived and then we'll move on and look at your own decisions and actions.

So, Henry, could we have up on screen please DHSC0100025_062. If you just, perhaps enlarge that slightly, Henry, so we can see this is a letter

22 August 1967. It's addressed to Dr Godber who was the then Chief Medical Officer and it's from Dr Rosemary Biggs at the Oxford Haemophilia Centre.

I just ask you if we could look at two or three of the paragraphs. Paragraph 3: this is referring in 1967 to the concentrates and she says in the first sentence:

"They are in very short supply in England and at present also scarce everywhere else in the world."

Then she goes on to set out her view of their importance. Then if we look at paragraph 4 the last six lines please, Henry, we can see that she's explaining she has good reason to believe that there will be commercial products made available from the US over the next couple of years. She identifies the number of donors and then explains that:

"We may be obliged to buy it at a very high cost for our patients unless the English shortage can be remedied."

Then if we go to the last paragraph on that page, last three lines, Henry, in fact that whole section thank you. She says:

"In this country we have pioneered this treatment, we have the personnel who know how to make the products, we could easily have enough plasma to

serve as starting material. It would seem to me a great pity if we cannot make our own material in this country for lack of the organisation, apparatus and buildings in which to work."

Then over the page she talks about the purchase of the finished products in the United States will undoubtedly be very costly and then last five lines:

"Surely it would be less costly to us to do everything to expedite the manufacture of these fractions in England and in particular to accelerate as much as possible the new fractionation buildings in Elstree and Edinburgh. I feel that it is perhaps time to try to reassess the quantities of these products that might be needed and to try to work out an emergency plan ... to meet that need."

So we can see this is some seven years before you take up the reins at the Department, the Department being made aware from a relatively authoritative source, Dr Biggs at the Oxford Haemophilia Centre, of her view that the question of UK production is something that needs to be urgently planned for.

A. Well, the only thing you can say is at least she was asking her into the department to advise them and she has had a fantastically distinguished career. If

I had to point any single one medical scientist and doctor I think I would say she is, because she gives the unvarnished truth which she writes, she does proper research and she puts it out into journals where it will be read. So she has done a -- she did a fantastic job and her voice was there firmly inside the Department in their advisory capacity. So I think -- it's all there. The evidence is all there. It's in Titmuss' book as you say in 1970 and it was there in numerous medical journals.

I mean, I say I stay out of this, I'm not a doctor, but I mean I was in '67 a research worker at St Thomas' Hospital basically working with distinguished neuroscientist who was my exact contemporary, David Marsden, on Parkinson's Disease. I was reading The Lancet and the British Medical Journal all this time and all the time I was a Minister of health. I mean, that was my sample. A lot of these articles I read in my home.

Q. Now, the Inquiry will obviously be looking at what did or didn't happen between 1967 and 1973 but we'll pick up the threads again in 1973 and if we could just have up on screen please, Henry, DHSC0100005_033.

We're now March 1973 so we can pick up the picture up here about a year before you join the

Ministry. This is a letter from the Chief -- a communication from the Chief Medical Officer to all senior administrative medical officers and we have referred to this kind of communication that was within the CMO's remit.

We can see if we look in the third paragraph -- sorry, the second paragraph we can see the Chief Medical Officer recognising that the production of the concentrate in the UK is at present insufficient to meet the stated needs of clinicians.

If we go to the next paragraph, we can see:

"As predicted by Dr Biggs in 1967 we now have concentrates, commercial concentrates, product licences having been granted to two firms", and then if we pick up the next paragraph, please, we can see there the decision of the Department at that stage is to assemble a group of experts to advise on likely trends and methods of treatment, possible future requirements for the treatment of the condition and the consequences for the supply of the therapeutic agents.

That I think is the expert group that you referred to in your witness statement, Lord Owen.

If we could just have a look at an exhibit to your witness statement, we also have it at

PRSE0004706.

As I say, you referred to this in your witness statement Lord Owen. It is a meeting of the expert group on the treatment of haemophilia on 20 March 1973. We can see there Dr Reid, that's the deputy Chief Medical Officer that you referred to I think, Dr Biggs, Dr Maycock we've got a Dr MacDonald from the SHHD, so representing Scotland and various other officials.

If we go please, Henry, to the second page -- thank you -- we just see under the heading 3, "Comparison of therapeutic materials". You'll see there, Lord Owen, a reference to cryoprecipitate and then underlined a few lines down "freeze-dried concentrate".

You have touched on this already in your evidence, Lord Owen, but can I ask you this: as the shortfall in production in the UK became apparent to you when you were Minister, was any consideration given by the Department to the increased or continuing use of cryoprecipitate or the issue of any guidance in relation to that or was that regarded as a matter for the clinicians?

A. Well, as I say, cryoprecipitate was the easiest thing to do, didn't need a new factory or something like

that for that. That was the treatment of choice up until AHG started to come on which, for reasons which we said, was preferred by doctors specialising in haemophilia and, broadly speaking, by patients, whether the parents or the actual patient who was having it.

So by the time I was there we were already buying from America and we were trying to increase, firstly, the number of transfusions so that the pool of blood would be larger, that we were trying to get expansion of Elstree and Oxford, which are the two main ones that were making the concentrate, and then later on I tried to ensure that Scotland was brought into the Department for discussions and to see whether or not (a) we could share my expertise more but also utilise the facilities to expand Scotland's production in order to help overall UK production.

So all these things were coming along but at a slow pace and with an increasing and well-known change, I mean Dr Maycock is on the World in Action programme but Dr Maycock wrote papers which were quoted by Rosemary Biggs in her main paper about the calculation of the danger, a ten times larger chance of getting hepatitis if you use the American product, commercial product.

So I don't know where your leaning is. I mean, should the medical officer of health come to a conclusion that you should stop it, all imports? Very difficult. You've got to try to put yourself in the position of these groups of people. The fact that Rosemary Biggs is there, she's all the time raising the question. She doesn't say "Do it", she raises the issue. So you've got to face it. And that's why her involvement on the advisory body was so important. But there were other names there of people I recognise: Professor Hardisty, who is the expert on this in Great Ormond Street, who I knew personally *[redacted]*.

So you knew these were good people wrestling with this issue, a moral issue. It is not new, you know, to medicine. There are many other areas, unfortunately, of medicine in which people are making these very difficult choices and all the time trying to give the patients a place in the decision-making. And we have -- as a society, have moved, really, to telling patients much more today, in 2020, than you would have done in 1970.

Q. As a matter of fact, as far as you can recall, and I'm very conscious I'm asking you about events a number of decades ago, was there ever any discussion within the

Department as to whether clinicians should be given encouragement or a steer towards reverting to a greater use of cryoprecipitate to solve this problem, at least in the short-term?

A. Yes. There's no doubt about it. It's in minuted evidence.

Q. Was there any advice that was given, as far as you're aware, from the Chief Medical Officer or others within the department to suggest that clinicians should not rely upon imported concentrate so much but should perhaps consider more widely the use of cryoprecipitate?

A. No, I think that they said weighing the decisions and taking account of how serious the haemophilia is. Remember, not every haemophiliac is having a lot of bleeds. The definite advice was if they were not suffering a lot, stick to cryoprecipitate. If they are suffering and it's leading to joint damage and permanent crippling, then they were saying -- and that's why they were saying we have to increase in the short-term.

Now, as I say, I take you back to the memo that asked me to make up my mind whether I was making the right decision, because I was going to deprive other areas of medicine and surgery and elsewhere if I put

money into this and effort into this, and my decision was yes. Now that is a political decision, and rightly so in my view. And why I was in a hurry to do it too. And you will see evidence in which we've set a time limit of two years, and then it slipped to three, and I got -- you know, I had a good private secretary too. Both of them were very able. They have gone on to successful careers. And they held the Department to account. That's the role of a minister, and to say, "Well, what do you need to -- we won't live with this extension for three years, what else do you need?" And so we found more money.

Now, I have no doubt that there was going to be more money that was spent, because you could see it. We were finding more successful interventions with AHG concentrate, and we had to produce more in the UK. Then we would -- so that self-sufficiency -- look, I don't know what happened to the Department when I left. I mean, I just simply don't know. But I do see that the then Secretary of State for Health in 1982, and in a letter to me I think from Baroness Trumpington, said: We are now introducing a policy of self-sufficiency.

Well, what the hell was happening all those years before? You know, I left the Department in '76.

So six years they're later making an announcement about self-sufficiency.

Now, that was the moment when I started to -- rather belatedly, I rather kicked myself I didn't start earlier -- to find out, try to find out, what was happening. And that's when we started to make -- try and use the Ombudsman thing. But that's another story, which ...

Q. We will come on to that.

Sir, I note the time. We were due to have a break at 11. My apologies.

SIR BRIAN LANGSTAFF: It is fine. We were in full flow.

So we'll take a break now. The breaks are 45 minutes. This is to allow you time to get to where you have to be, to your allocated seats, and to be served and to return. So it will be a 45-minute break for every coffee or tea break we have. So if you can come back, please, shall we say 12 o'clock but no later than 12, please.

(11.11 am)

(A short break)

(11.58 am)

SIR BRIAN LANGSTAFF: Just before you start again, Ms Richards, can I mention something which has come to light. Just at the start of the break, someone came

forward to talk about Tweeting. They had not, I think, realised that Tweeting what is said in this room, and has not yet been put on YouTube or the delayed feed, would be a breach of the order I made this morning.

I'm told that the person who came forward was very upset and very apologetic for what they had done and, given that we've spoken a bit about courage and openness and honesty this morning, I'd just like to say that I acknowledge their guts in coming forward to admit that they had broken my order.

They may not be the only person. I hope they are but, for that reason, I do not propose to name them openly. I am told to expect a letter of apology this evening and that seems to me to be sufficient action in that particular case and, as I say, I admire them for having the guts to admit what they had done.

But it sends a message to all of us, I think, that we just have to be careful. The words mean what they say. The purpose of them is to protect potentially damaging information. Damaging, that is, to confidentiality, which we must maintain. You are privileged, we are all privileged, in this hearing room, and for that matter those who are on the direct stream outside and have signed undertakings of

confidentiality, we are all responsible for that, and I'm sure most of us have done just that. But it's a reminder, I think. That's all I want to say about it.

Ms Richards, we can continue.

MS RICHARDS: Lord Owen, we had been looking at the minutes of a meeting of the expert group on the treatment of haemophilia in March 1973, and there's just one passage I want to draw your attention to then ask you about.

Henry, could we have that up again, please. Thank you.

It's the top three paragraphs and you'll see in the course of the meeting this is said, top of the page:

"It's essential that production and distribution of the therapeutic agents concerned should be considered as a UK exercise ..."

Then we can skip to the third paragraph:

"Close co-operation between England, including Wales and Northern Ireland and Scotland, will be required in order to co-ordinate and optimise blood collection and transport, the fractionation processes, distribution of the therapeutic agents, and utilisation of other blood fraction by-products."

Now, I wanted to ask you, first of all, Lord Owen, what the extent of your responsibilities were and the Secretary of State's responsibilities were in relation to Wales, Northern Ireland and Scotland? And I suspect each fall to be treated differently at that time.

A. Well, health was not a devolved power, in the sense that we didn't have a Scottish Executive like we have now, but the -- there was a Secretary of State for Scotland with considerable powers for Scotland through his office. I think at the time Willie Ross was the Secretary of State for Scotland, so I think the Blood Transfusion Service would probably have come under him in Scotland, and -- but they were meant to be collegiate. And I think I did mention, when I was answering a question about the American company that was asking for a request, I actually did ask, but I think I could only ask that they would consult with Scotland at their next meeting about this very issue of co-ordination, and they did do it and they also enclosed the minutes of this. That was, I think, in 1976.

So it was -- it did concern me. Of course, the really critical article of the Blood Transfusion Services UK-wide from the Scottish director, Cash,

that was in 1980, I think, in the British Journal -- in the BMJ.

So the answer is, I think, the regional transfusion centres also prided themselves that they were independent decision-makers. I think the department thought they were a little bit too independent, and that was one of the reasons why we put this capital injection of half a million into the self-sufficiency programme, so that we had a -- the department had a stake. Then people like Bob Reid would talk to Regional Medical Officers of health, who were usually represented on the board of the transfusion people, to try to get some inner coherence for the UK as a whole.

Q. So in relation to Scotland, it would be the Scottish Home and Health Department that would have primary responsibility -- is that right -- for matters of policy but you would expect close liaison between the department of which you were a member and the Scottish department?

A. Yes. Ultimately, if it got very bad -- I did, I think I mentioned it -- we asked Brian Abel-Smith to look at the whole question. He was, really, principally Barbara Castle's adviser, but he was respected and he did call together to try to get greater co-ordination.

But if we had felt really something needed to be done, which we might well have done after I left in -- this was an issue for '76, really, from what I remember, but you are right it was pointed out in '73 as being important -- the Secretary of State, in Barbara Castle's case, she would raise it directly with Willie Ross rather than -- probably I would write to him. It would go up at -- Cabinet Ministers.

Q. What about the position in relation to Wales? Did the same apply in terms of the Welsh office? What was the position then?

A. Well, the Welsh office started to get more powers as the whole devolution issue started. But I'm afraid I can't quite remember. In '74 it was in its infancy. It had started. There had been a Secretary of State for Wales for quite a long time, but by and large anyhow the Welsh and the English Health Service works very closely because there is a -- a strange border, and people go from England to Welsh hospitals and from Wales into English hospitals because it makes sense in terms of catchment area and they don't -- they ignore the boundary line and there's cross-financing arrangements.

And broadly speaking -- I mean, I'm 100 per cent Welsh, I have no English blood in me at all -- by and

large -- that's my prejudice. So by and large I think Wales and England have no difficulty and never have, really. There's been a good relationship between them. The frostiness has come a little bit in Scotland. And may be always there, I don't know.

I mean, Scotland has, you know, the Royal College of Physicians in Edinburgh and Glasgow and the Royal College of Physicians -- and first-class medicine. There's a lot that is very good about the Scottish healthcare, as I've watched over the years, and very high quality. I'm not making disparaging comments.

Actually, in this case, they had the capacity to expand, and it seemed only sensible to utilise that capacity as a cost-effective way of expanding.

Q. Then what, if anything, can you recall about the position in terms of Northern Ireland? Who had, as it were, policy responsibility in terms of blood safety, blood products and the like?

A. Well, again, as devolution took place, more and more power went to the First Minister and this Stormont Parliament. But, I mean, Stormont had existed for quite a while but, again, there was direct rule for quite a long time, so in which case the Secretary of State for Northern Ireland under direct rule, and

I think direct rule -- well, I was in the Ministry of Defence as a junior minister for the navy when we went in and took control of Northern Ireland, and that was 1968.

Q. Do you recall -- again, very conscious that these are events a long time ago, do you recall whether there were any particular discussions or involvement of the Secretary of State for Northern Ireland or the Chief Medical Officers in relation to Wales or Northern Ireland?

A. I think the Chief Medical Officers worked very well. You've seen this in COVID now. I think the Chief Medical Officers left to themselves would have no problem, I agree. So I think sometimes it's the politicians that are more the problem.

I don't want to exaggerate. I was beginning to sense there was a problem but I didn't think that Blood Transfusion Services -- it was not a big problem for me in '74 to '76. I began to realise it was more of a problem later. And then there was this, you know, very serious criticism of the Blood Transfusion Services in the UK. Which may not have been -- you know, it's just one man's view but it was -- I think a lot of people felt it needed to be said, that article in the BMJ, but that was 1980.

Q. Can I then come on to your time in office directly and a handful of the documents relating to that. I want to pick it up, if I may, with a document in June 1974. Henry, it's DHSC0100005_135.

So you will see, Lord Owen, this is a meeting on 26 June 1974, so you are currently Parliamentary Under-Secretary of State. And if we go down, please, Henry, to paragraph 2.2, the issue here is about the central contracting arrangements that had been put in place in relation to the US imports.

Then 2.2 says this:

"When the central contracting was first discussed in March 1973, it was hoped that UK needs for AHG would be supplied by the BTS by mid-1975. Dr Maycock said this would not now be possible nor could he give a revised date at this stage because of financial stringency. Further contracts would therefore be necessary for at least another year and possibly more."

Had you been aware that the aspiration as at 1973 had been there would be self-sufficiency by 1975?

A. Can you go to the date again?

Q. Yes. 26 June 1974.

A. 70 ...

Q. '74.

A. June '74.
Q. So this is before your --
A. Well, I think the answer probably is "yes", in that we knew that -- I couldn't -- I was aching to make a statement that we would be self-sufficient and I couldn't do it. This had to be sorted out. They took it on, my -- the staff in the department, and there were these two -- there was Elstree was in trouble, Oxford was in trouble on AHG concentrate, and one other -- of the regional ones had financial problems, I seem to remember.

So we had to go back to them to get them all signed up. That's what we used to talk about. It's signing up the regional health people to self-sufficiency. And then I wanted to announce it to Parliament as soon as I could. And that was only in, I think, January '75, when -- in a written question. And that was a sort of -- I tagged it on, really, to a written question which was about whether or not we had enough supplies. The answer was, of course, we didn't.
Q. But let's look at the announcement that you made in January 1975, Lord Owen.

Henry, I think this is right, DHSC0046887.

We can see from the top it's a written answer,

as you recalled, Lord Owen, 22 January 1975.

If we can go to the bottom of the page please, Henry.
A. Yes.
Q. I think it is worth looking at the whole of your answer here:

"The amount of Factor VIII materials including cryoprecipitate produced within the National Health Service is not sufficient and in particular there is a need to provide more human AHG concentrate, which is now the preferred treatment for haemophilic patients. There is also an increasing demand for certain other blood fractions. At present part of the demand for AHG concentrate is being met by imported material, but this is very expensive and, for reasons which I well understand, health authorities feel they cannot afford to buy as much as they would wish to, given the various claims on their resources."

Then you say this:

"I believe it is vitally important that the NHS should become self-sufficient as soon as practicable in the production of Factor VIII including AHG concentrate. This will stop us being dependent on imports and make the best-known treatment more readily available to people suffering from haemophilia.

I have therefore authorised the allocation of special finance to boost our own production with the objective of becoming self-sufficient over the next few years."

Then if we can just look at the answer you gave the following month, and then I want to ask you some questions about it.

So, Henry, its DHSC0046888.

I don't know whether we can have them side by side but don't worry if you can't.

So this is an oral answer that you gave on 25 February 1975. We can pick it up second left-hand column:

"I have authorised the allocation of special finance of up to £500,000, about half of which would be recurring, to increase the existing production of Factor VIII especially in the form of anti haemophilic" --

SIR BRIAN LANGSTAFF: I am not sure we are on the right page.

MS RICHARDS: Yes, it is the right page, sir.

SIR BRIAN LANGSTAFF: Thank you. Got it.

MS RICHARDS: "... especially in the form of AHG within the National Health Service. The first effects of this will I hope be felt by the end of the year."

And then if we could go down the page, please,

we can see in your next answer you refer to the desirability of the treatment but it being one of the many costly treatments competing on priorities.

Then if we could go to the next column please, Henry -- so same page, thank you -- and then we see your answer here:

"They [that's the Regional Health Authorities] are aware of it, our concern, and have had ample demonstration of it by the fact that we are prepared to divert scarce resources to make the NHS self-sufficient but I can see that it will take two or three years before we are at full production ..."

And then you refer to perhaps individual cases being weighed very carefully.

In those two announcements, Lord Owen, made by you to Parliament, you've set out a goal of self-sufficiency. Can I just ask you, was that in your mind a mere aspirational hope or was it now a firm Government policy that the UK would become self-sufficient?
A. I think it was a pledge. I think when you are diverting money from Central Government to the regions, then I think you have to announce that to Parliament and that's really -- this is a more important announcement. This was an add-on in the

first one to a written question. It says there's going to be money but it actually tells them how much money is being put. All through this, the 80s and everything like that, I've always said you couldn't move away from self-sufficiency without telling Parliament. I mean, you can change policy but the advantage of doing this is that you are making a pledge, and you couldn't resile from that without going back to Parliament. And I don't think we ever went back to Parliament.

From the time I left, I've never been able to find any statement which said we were no longer doing self-sufficiency. It was always claimed that we were, in a variety of complicated ways, but Parliament was never told that it was not doing it. And therefore, to the argument, "Well, you didn't provide the resources", I couldn't provide the resources. I explained it was quite difficult to make anything more than one year as a forward commitment. But if you make a commitment to a policy, you are binding your successors to find the resources, within reason.

I think that that's the importance of Parliament.

The other thing we should remember is that there were Members of Parliament who were becoming

very concerned about this issue, and the outstanding one was Alf Morris. He was in the department all this time, looking after disability, and he was seeing -- I think he was the first Minister for Disablement -- and he was -- firstly we discussed it every week, you know, all of -- when these things came up collectively, ministerial, but he was seeing the consequences in the disabled children who were coming up with haemophilia, and he never, ever shifted from it. He's an outstanding demonstration of a member of Parliament who gets the bit between his teeth and consistently pushes and pushes and pushes, all through the 80s and 90s. He was behind the Archer inquiry, and his contribution, I'd like to say publicly, was a magnificent one. Quite frankly, he used to come and put pressure on me to do more.

Q. Can I suggest to you there are three particularly significant things about the two announcements that we've just looked at in Parliament. The first is the one you have alluded to. This was a statement being made -- in your terms, a pledge to Parliament?

A. Well, it was talking about better treatment, which, if you like, is a euphemism for UK treatment, UK resources.

Q. Secondly, we see you're committing a specific sum of

money, and you say about half of which would be recurring; so it's an ongoing commitment financially in that sense.

A. Mm.

Q. And, thirdly, you've put a timescale -- it's not an absolute or precise timescale but it's an expectation that it will take two to three years?

A. Yes, and when that was pushed further along the track and went over three years, I objected when I discovered this. And we had a meeting and we called to account, and they went away and put it back on track, and I told them that if it happens again I don't want to be told about it -- you know, I want to be told about it as soon as it happens so we can put remedial action in tow.

These things slip because understandably everybody's got higher priorities, or what they think are higher priorities, and it's not, you know -- chronic illness which a lot of these people would come under the classification of chronic disability, we've never been very good at treating and that's why the Minister for Disablement came and Harold Wilson attached a lot of importance to that post and so did many other ministers. John Major actually I think held that job as his first job in Government and he

then took that commitment into being Prime Minister.

So the disabled provision has become a lot better than it was. It's still not enough and it is still not enough in terms of income and, you know, there is, Mr Chairman, you alluded to it in your letter to Penny Mordaunt that the Government is still not, while this Inquiry is going on is still in a situation where payments are more generous to people in Scotland than they are in Wales and England and that we are still, in my view, not fulfilling our financial obligation, particularly given that we were not self-sufficient in time.

Q. These Parliamentary statements don't in express terms talk about the dangers of imported concentrates or the risk of viral transmission, which I think is one of the points made by the Ombudsman years later. We'll come back to the ombudsman in due course.

Is there any particular reason you can recall why that wasn't spelt out in black and white in these statements?

A. Well, on the first one, as I say, we were riding the back of George Cunningham's written question, which is: what deficiencies exist in the supply of Factor VIII and cryoprecipitate for the treatment of haemophilia? If you look at -- the first paragraph

answers that question. The second paragraph says we're doing something about self-sufficiency.

The other replies, well, you know, sometimes you put the -- but we were still carrying on buying this blood and we were putting it into people's veins and we were utilising it and we knew we were going to have to go on doing that for at least two to three years. Until self-sufficiency took place, we weren't going to be able to stop it being used.

You know, this went on with the whole problem when AIDS hit us and in '83 again the question was put should you be allowing this to be used and the committee on safety of drugs said weighing all these factors, yes.

So you're on this delicate question. I mean, I don't think -- as I said, I didn't want secrecy but I didn't want to create fear in people who were having it. That's not my job. I'm not trying to explain it. That had to be what doctors said to patients, I don't want to go back over what I've said in full already.

It is very, very difficult to determine how much you should say to people. We get this wrong and we weren't -- informed consent really is the question now, thank goodness. We are trying to, as a medical profession, to be more open with patients and of

course it's, you know, you tap in on the thing, haemophilia and you'll have detailed things. You can look up Rosemary Biggs' article and read the whole thing. It's a completely different world we're living in now about medical information. Read a newspaper, Daily Mail has page after page about medicine and, you know, World in Action wanted to put it on the ... so it's a really difficult balance.

Q. I want to look with you at a couple of documents that precede your announcement just to see what the plan was and where the figure of 500,000 came from. If we could have please on screen, Henry, DHSC0100005_171.

We'll see that this is a minute dated 15 October 1974, so it's the autumn before your January 1975 announcement. If we pick it up in the third paragraph we can see it says:

"Increased production depends in the first place upon an increase in the amount of plasma made available by the 14 regional transfusion centres for fractionation at the Blood Products Laboratory. Extra production of plasma requires in varying degrees in different regional centres additional facilities in terms of equipment and/or staff and/or accommodation. A rough estimate of the cost of equipment and staff required is approximately £500,000, most of it

recurring. Recent reports from regional transfusion directors indicate that RHAs are not unexpectedly unable to make the necessary funds available."

Then if we just look at the next paragraph please, Henry:

"We are intending to discuss the present impasse with regional officers. It is not only a problem of finding the money to provide more facilities for the separation of plasma from whole blood. It will also be necessary to persuade clinicians to accept a great deal more blood in the form of concentrated red cells than they do at present; this will require much time and effort."

Can I just ask you about that second point first of all, Lord Owen. Maybe this is not an issue that came to you as Minister but do you know whether the department or the Chief Medical Officer took any particular steps in relation to that second goal, persuading clinicians to accept more blood in the form of concentrated red cells?

A. Well, the writing says with regional officers. I assume since this is fairly detailed that they meant Regional Medical Officers but it's not absolutely clear.

Yes, I think -- it was continuous dialogue about

this and if you look at the minutes of the advisory committee, you know, Rosemary Biggs didn't shirk from telling them, nor did the other doctors. I think the -- there is a time delay. I mean, there was a problem with BPL that it hadn't had enough investment and, again, you know, we flogged off BPL in 2,000 and was it 5? 2015 or something, I've forgotten now, when the Secretary of State Hunt was in charge for the Health Service. I posted. I actually wrote to the Prime Minister, then David Cameron, and said there are certain assets which should not be commercialised, and one of which was the Blood Products Laboratory. That was then sold off to Bain & Company which is a company that just fattens people up, investments it up, and then sells them on, so Bain after three years sold it on. National Health Service took 25 per cent of this, so they got some return and then it ended up into another company which owns it now and that company is headquartered in China.

When will we realise? When will we learn that there are certain assets which you need to control inside your own country? We saw this with COVID. We tried to get material and people were bribing planes to bring it to us. Why didn't we have some of this self-sufficiency elsewhere? I mean, what is the point

of having an NHS if you don't -- we did build up supplies of protective equipment but then nobody inspected them and so then when the time came a lot of it was defective.

I'm not making political points here. I'm just trying to get people to understand that if you are dealing with health, there are different rules apply. Governments protect their own citizens. It doesn't matter if they have got export orders, they look after their own citizens. We do the same.

So if you are completely dependent on foreign companies, I mean, President Trump makes no secret of this but actually it's happening in all governments around the world. They are closing down their own assets first and bound to do so facing a world pandemic. You've got to have -- self-sufficiency is not just a slogan for haemophilia. It was a slogan for AIDS, it was a slogan for Jakob Creutzfeld Disease and it will be down the track for another unknown virus that will hit us. As I said, there is a way of dealing with COVID through fractionation.

Q. Can I just ask you to go back to this document, paragraph 3, the rough estimate of £500,000, most of it recurring. That's the sum that was in fact secured and made available. It's described there as a rough

estimate.

Do you know whether there was ever a more polished assessment or was it a question of 500,000 is what we can get from the Treasury?

A. Well, I don't think the Treasury would interfere with it -- I've said some tough things about the Treasury. It's very easy to blame the Treasury. I think the Treasury and indeed the Department in their original warning note to me is am I aware of the fact that other areas will suffer? Yes, is the answer. So if you take half a million away from it you are not -- you've got less -- half a million less to spend on other things.

But if you are making a commitment to a policy pledge, like self-sufficiency, as you said, some of it was admittedly recurring. Now, I'm sure that my successor, Roland Moyle, contributed more financial resources but when he answered questions about what had happened as a result of this 500,000 injection in I think '78 -- no, I get my figures wrong. I left in '76. '78/'79 they looked back on years '74, '75, '76 when I'd been -- all show that it had an effect. There was increased blood, there was increased concentrate, increased precipitate. So it was working.

I don't deny that because demand grew you had to find more money. That does not, in my view, call in question the policy of self-sufficiency, unless you go back and say we can't afford it.

SIR BRIAN LANGSTAFF: If I may, the word I think that counsel was focusing on was the word "recurring".

A. Yes.

SIR BRIAN LANGSTAFF: The £500,000 you have described as a capital sum.

A. Yes.

SIR BRIAN LANGSTAFF: If it's recurring it becomes essentially a repeated or revenue expense, does it?

A. Yes, it goes on --

SIR BRIAN LANGSTAFF: So the policy lived in the hope that the regions would find out of their budgets £500,000 or thereabouts, most of £500,000 a year in order to keep the policy going.

A. It depends on them chipping in, yes, extra amounts, or giving an increased grant to the Blood Transfusion Service. But this is paid for -- in those days there were Regional Health Authorities and they then were the allocator to the transfusion services. So the debate would take place. We had, I think, more control over the Regional Health Authority politically than we would have over the individual transfusion

service. So it was more persuasion there.

But if we had come to a conclusion that not enough was going, you could have called in the chairmen of the Regional Health Authorities and asked them to increase the -- and they would always do that.

SIR BRIAN LANGSTAFF: Thank you.

MS RICHARDS: The word I was first focusing on was "rough", "rough estimate", an approximation, £500,000. I was simply wondering whether, to your knowledge, was there any more precise analysis or assessment undertaken because this is the figure that in fact was the figure that you announced in Parliament four months later.

A. I should think it probably were those figures. I mean, a rough estimate of the cost of equipment and staff required is approximately 500,000, most of it recurring. Do we state anywhere how much it was recurring? Half of it, 250,000 from my memory was recurring.

Q. Yes, that's absolutely right. That was your ministerial statement of 25 February. So this had identified a rough estimate that the need was for most of that to recur. What you were actually able to offer Parliament in January and February 1975 was 250,000 capital and 250,000 recurring.

A. But my answer is it did the trick. I mean, the figures are there in the answers to written questions both answered by the ongoing Labour Government when I was Foreign Secretary but then also by the incoming Government in '82. They didn't deny that it had an effect. The question is when did it stop, when did it run out? I don't know. It certainly had run out by '82 when Mr Clarke makes the statement we're going to start a policy of self-sufficiency.

So I can't answer really, you know. I mean, you do close the door when you leave and I was off on fairly taxing jobs. So I'm afraid I didn't focus -- I kick myself for this but I didn't really focus on this until '82 and even then it was '85 when we really knew that something was seriously wrong.

Q. I want to look at a memo that you have referred to in your evidence already.

Henry, it is DHSC0100005_189. If we have the first paragraph please, it's dated 9 December. It says:

"Since Dr Raison and I discussed with the Minister of State [that's you] last week the question of supplies of AHG concentrate, we have established within the office that earmarked central finance to the extent of 0.25 million capital and 0.25 revenue

can be made available to regional authorities to increase NHS production of this material."

Then there's a passage I think you have alluded to Lord Owen:

"We have been asked to draw attention to the fact that a decision to make this special allocation of resources to blood products production inevitably means that less money overall will be available for other high priority health authority services, eg mentally ill, mentally handicapped, family planning, and certain centrally sponsored projects, such as schemes to reduce waiting times. But there is broad agreement that such an allocation would be justifiable."

Then if we have the beginning of the next paragraph please, Henry, then it says:

"If the Minister of State confirms his intention to take special measures to increase production of AHG concentrate, we could write in the following terms to have several MPs ..." and then there's a suggested draft letter.

The language of this suggests that there may have been a degree of, as I think you suggested in your evidence earlier today, a degree of difference of opinion within the Department as to whether this was

the right course because of other competing demands. This memo seems to make clear that it's very much being presented to you as a decision for you as Minister to make; is that right?

A. That's what you're there for. I mean, you're answerable -- and you're even answerable when you're 82.

Q. If we could just go to the last paragraph of this document, Henry, so it's on the second page, it says there:

"During our discussion last week mention was made of a possible arranged PQ ... I am somewhat doubtful about this since the main pressure is for additional money to buy the commercial product now, however you will no doubt take the Minister of State's view on this."

Then I want to show you your response and then ask you a question. The response, Henry, is DHSC0100005_191.

So you say here -- this is 11 December, it's said here:

"Dr Owen has seen your minute of 9 December ... has agreed the submission. He would like one change made to the suggested new standard reply for MPs. In place of the second paragraph you propose he would

like inserted suitably amended versions of the first and second paragraphs of the draft letter to regional administrators which you also submitted for approval. He has commented that 'it is time MPs knew the full arguments'. He would like to know if there is any objection to this. With reference to paragraph 4 of your minute, Dr Owen has commented, 'I agree that we should not court publicity'."

Dealing with the second point first, why was there an issue being raised here about publicity and the possible downsides of publicity?

A. Well, Mr Gidden for the first one, from what I remember, was our representative of the Treasury and I think he was, if you show it up again, he is warning about the dangers; isn't that the issue?

So I take his warning about not courting publicity but I say it's time the MPs knew the facts.

Q. The reference to the MPs knowing the full arguments seems to be on the basis you wanted some additional material inserted into what was going to be a standard letter to MPs.

Can we look at -- we haven't got the precise draft but we've got the final document that went out. It's CBLA0000239. This is a letter to -- the letter to regional administrators and you've asked in the

minute of 11 December for some parts of the first and second paragraphs of this to go into your letter to MPs. We'll see the first paragraph is about the inability of the National Blood Transfusion Service to meet demands for concentrate and then in the second paragraph you say or it says this:

"At present part of the demand for these blood products is being met by expensive imported material which is now marketed in this country. As demand increases commercial firms may consider it worth their while to establish panels of paid donors ... such a development would constitute a most serious threat to the voluntary donor system upon which the NBTS is founded. The Department, therefore regards it as of the greatest importance, quite apart from the question of cost, that the NHS should become self-sufficient as soon as practicable in the production of PPF and other blood products ..."

It would appear that you wanted to have in the communication to MPs a statement of your, as it were, allegiance to the voluntary donor system and the importance of that system; is that correct?

A. Yes, for the same reasons as *The Gift Relationship* and my review of it in the New Statesman.

Q. Then I think we can see, in fact, you are advised

against that. If we look at DHSC0002327_046.

A. I keep wanting to flick it up. I haven't seen this document and, of course, as I think most people know I don't -- I lost access to all my documents, so I haven't seen that.

Q. I think these are part of the materials you have had for the purpose of the Inquiry evidence.

A. It's wonderful the way you've found all these documents. I congratulate all the people who worked so hard to get them.

Q. So this is a minute of 13 December from Mr Gidden to Mr Alexander:

"We have recast the second and third paragraphs of the new standard draft to MPs incorporating more of the substance of paragraphs 1 and 2 of the letters to regional administrators but we would strongly advise against any reference to the point about the paid donor panels. There are advocates in this country of the paid donor system and public debate cannot, we believe, be of any benefit to the NBTS. Furthermore, if the Minister of State were to refer publicly to a threat to the NBTS it could be taken has been a form of challenge to the firms concerned and cause controversy. There is perhaps the additional point that to complete the story the Minister of State would

probably need to hint at legislation to obviate the threat, since there is at present no legal bar to the establishment of paid donor panels."

If we see the whole of that document -- Henry -- we can see that you accept that advice as the handwritten note?

A. Yes, but when I first went into the department you no doubt found a piece of paper which said that I thought that we should ban commercial donorship of blood, being paid for blood -- and also semen, ban the sale of semen. Unfortunately, that was rather naive and they pointed out to me that would require legislation. That impeded on huge numbers of market principles and other things and would be very controversial and probably wouldn't get it through. So I had to learn. And I learnt my lesson; I couldn't do that. So I had to stop. And that -- he'd picked up what I was implying was that was where you could go down that route, but I don't think you could go down that route. We wouldn't get it through Parliament.

Q. Yes. And there is a subsequent memo in which you expressly raised the prospect of legislation, and you refer expressly to the Titmuss book.

A. That was -- you know, we had a majority of four or something like that at this juncture.

Q. Can I then, just moving on in 1975, ask you to look at, again, a couple of documents. The first is a minute of 17 March 1975.

Henry, it should be at LDOW0000018.

This has been prepared for your benefit because we can see it says under the heading, "AHG production, Dr Owen's minute below". We can see here, as it were, the detailed plan, so I just want to spend a little time going through it so we see what the plan was.

"Immediately after the decision was taken in December last to invest half a million of special finance in AHG concentrate production, provisional targets of plasma production were drawn up for each of the 14 regional transfusion centres. These were then circulated to regional transfusion directors and discussed with them at a special meeting on 19 February. The targets have now been revised and we shall be asking Regional Health Authorities next week to indicate the amounts of money required for extra staff, equipment, transport and adaptation of accommodation."

And there's a reference to a draft letter and processing the returns as speedily as possible.

Then if we see under the heading, paragraph 2:

"The timetable for starting up this programme is

likely to depend on the time taken for:

"(a) delivery and installation of three Sharples centrifuges at Blood Products Laboratory. The quoted delivery period is six months. This is evidently the key factor determining the speed with which we can get on. We shall pursue this to see if we can shorten the period.

"(b) adaptation of premises at regional transfusion centres and Blood Products Laboratory; at the latter laboratory recruitment and training of staff may be a problem."

Then there's a reference to a possible risk of time taken to deliver and install certain other items of equipment.

Then if we can go to paragraph 3, please, Henry.

"Whilst the equipment is being delivered and any necessary adaptation of premises made, we are assuming that directors will be successful in persuading clinicians to accept a steadily increasing proportion of blood in the form of concentrated red cells, since this is yet another possible limiting factor. But we are proceeding on the basis of immediate progress once the equipment is working. Meanwhile, we can expect that the rate of production of fresh frozen plasma with existing resources will continue to increase,

which will help marginally in the interval before the planned programme gets underway. NHS production of AHG concentrate increased from 5,927 bottles in 1972 to 9,624 bottles in 1974."

Then over the page, please, Henry:

"Much effort will be required of regional transfusion directors, some of whom may not see eye to eye with their clinical colleagues treating haemophiliacs. For example, some haemophilia centre directors envisage home prophylaxis, whereas the present proposals are based upon home treatment of a bleed when it occurs. Other haemophilia centre directors apparently are not fully persuaded of the practicability and value of home treatment. There are therefore several clinical issues involved, but this need not delay the start of increased production. It should be noted (a) that Factor VIII concentrate has not previously been prepared in the NHS on the scale envisaged. This will in itself almost certainly give rise to some problems. And (b) the procedure of fractionation is constantly under review with the purpose of improving the yield of Factor VIII from plasma. At present this is 30 to 40 per cent.

"6. We will report again at the end of next month when we should be able to see which centres are

able to get off the mark quickly and give some estimate of the rate of increase of AHG production.

"7. Dr Owen also suggested we might consider issuing a letter to authorities asking them to view demands for the supply of the commercial material with sympathy. This could cause irritation if conveyed in an official letter. We suggest instead we might make the point in answer to further PQs which we are almost certain to get."

If we just go to the top of the first page again, please, Henry, there is some handwriting which I think -- is that yours?

A. Yes, my handwriting.

Q. "Noted. I look forward to the future report promised in 6 and I agree with the advice in 7."

This is, as it were -- this is the plan.

A. Mm hmm.

Q. You've announced the pledge in Parliament. This is the work being undertaken, being reported to you, as I understand it, to deliver that pledge?

A. Yes.

Q. We can see then, if we pick matters up again in 1975, in the middle of 1975 there was a World Health Organisation guideline that you referred to in your statement.

Henry, could we just put that up, please, PRSE0003476.

If we can just pick up the date, so it's a World Health Assembly resolution of May 1975, "Utilisation and supply of human bloods and blood products", and:

"The 28th World Health Assembly conscious of the increasing use of blood and blood products [et cetera, et cetera] noting the extensive and increasing activities of private firms in trying to establish commercial blood collection of plasma for rhesus projects in developing countries, expressing serious concern that such activities may interfere with efforts to establish efficient national blood transfusion services based on voluntary non-remunerated donations, being aware of the higher risk of transmitting diseases when blood products have been obtained from paid rather than voluntary donors, and of the harmful consequences to the health of donors of too frequent blood donations, one of the causes being remuneration."

Then Member States are urged to promote the development of national blood services based on voluntary non-remunerated donation of blood.

What you have said in your statement about this, Lord Owen, is you were aware of it at the time and it

was part of your continued decision-making to try to ensure that the department kept on top of delivering the pledge?

A. Yes. There's no inconsistency, if that's what you're after. Surely what you are saying is you want self-sufficiency. You can't get that for two to three years. During this time, there are -- out there, many, many patients are demanding the new AHG concentrate, as being better treatment for cryoprecipitate. And so you're saying to people, "You in the meantime, until we are self-sufficient and we've got all these extra things, you are going to have to buy more cryoprecipitate."

I was saying -- I was ready to say to them: You've got to do this, against all my wishes, because that's -- we were trying to meet the demands of patients in the first two to three years, we are going to need more of it. And they are saying to them: Look, they don't want to be told this message and they won't react against it because they know the consequences of it. It's better for us to do this orally to them and explain the timing and framing of it than you putting it in a letter, which anyhow they don't like being told what to do anyhow because they know a great deal more about it -- they think, and

probably rightly so -- than the department.

So that's the sequence of events, and it's up to me to decide. You either go full frontal and tell them or you tell them quietly that this is the consequence of this, and you are building up a pool of people of course who are going to be using this for their lifetime, and you are hoping that in three years' time you will be able to supply all from British donors.

And then a word of caution. I mean, some British donors won't tell you that they have been yellow, and hepatitis, and you will get -- and that's -- again, we're trying to have a lower pooling, less pooling if possible, and again, those people who are mildly affected, to really hold out and keep saying to them, "You must stay on cryoprecipitate and not go for the more convenient riskier one."

So all this has been handled by these specialists in haemophilia. By now we've got people more or less across the country who are specialists, often pathologists, who are also now seeing patients, rather pleased, actually, to coming back to seeing patients, dealing with a new treatment which can actually -- from the pathology and the -- the laboratory, if you like -- help them. They are

conscious of all this. And they are trying to -- and they supported the policy. As you said in the earlier thing. But it was finessing the problem of the two to three-year gap before you could be self-sufficient. We wanted to get to that point at the earliest possible opportunity because you were doing what you didn't want to do, which was buying in contaminated blood.

Q. We can see if we look at a document from, again, mid-1975, you're asking about the timescale.

Henry, it's LDOW0000019.

It's a memo or minute of 11 July 1975, and we can see from the first paragraph:

"Dr Owen has commented on PQ 3474."

So presumably a written Parliamentary question -- and proposed answer:

"Once again we are a two to three-year timescale. I have asked if we can improve on this. Can I have a note?"

Then I think this is, I think, the note that you have asked for. And you are told here -- I won't go through the detail of it paragraph by paragraph with you, Lord Owen, but you are told here what the response of the regions has been, and you are told, in paragraph 4:

"The main reason why the programme can't be completed earlier is that in four regions extensive alterations have to be made to the transfusion centres before they are in a position to provide more plasma."

Then there's reference in the end of that paragraph:

"We're having difficulties about the date of delivery of three Sharples centrifuges for the Blood Products Laboratory. We are pursuing this and hope to resolve the matter soon."

Then, paragraph 5, we are told that there were two regions whose ability to contribute to the programme was at present uncertain, and it's hoped that they can be brought in.

Paragraph 6:

"It's difficult to be precise in estimating a date for achieving self-sufficiency. Not least because not all are agreed as to what constitutes self-sufficiency. Some Haemophilia Centre Directors envisage prophylactic treatment whereas the Department's programme is based upon home agreement of those patients for whom treatment at home can be recommended."

Then, in paragraph 7, the note returns to the timescale:

"We can now say we expect to be self-sufficient within two years or alternatively that within about a year we will be able to meet some two-thirds of present requirements and become self-sufficient in 1977."

Again, can we just go to the top of the page because I think we have your handwriting again there. I'm lucky because I have a typed version of it as well. I think it says:

"This is excellent and I recognise that everyone is doing everything possible. I believe we should keep up the pressure. Can I be kept informed on the centrifuges and also the two regions, why are there difficulties and what can be done. I would not easily accept that they should not contribute."

I just wanted to ask you about the point that's made in paragraph 6 of this minute: a lack of complete agreement on what constitutes self-sufficiency.

Your pledge of self-sufficiency, as I understand it, and as this minute seems to make clear, was on the basis of making sufficient concentrates domestically available to enable home treatment for bleeds but not to meet all prophylactic requirements; is that right?

A. Well, you know, I mean, this is -- I'm glad you've got this. This is what political control is about. The

Department will have let this slip on to three years, because they are under so much pressure from -- so if you want policy, this is what a politician's there for. You tell them you're not going to let this slip, programme. They come back with a detailed argument that we can stay within the timescale that we've introduced. And -- very ingeniously, and they are also watching all these things, but even so we are saying to them -- you can read it there -- there's a problem over these centrifuges, I want to know if this problem comes up furthermore.

So we're trying to all the time to keep the Department on to the pledge that we've made. They are not resisting it. And then they say and warn about this -- I mentioned it earlier in my evidence -- this prophylactic thing, and I think I explained it, but whether I should explain it again, I don't know.

Q. It's clear from this --

A. Prophylaxis is you are actually giving them Factor VIII in their bloodstream all the time, so they never bleed, or you were having available at home, instead of going through to hospital and all the problems with the plastic bags and everything, which the family can inject pretty quickly and you can stop the bleed.

Of course, prophylaxis is the best. I mean, that's -- prevention is better than the cure but it would cost so much more money and we stuck to that but eventually we had to accept because these doctors make the decision and they went more and more for prophylaxis which, you know, if you had a child with it you'd want prophylaxis and, you know, I think of self-sufficiency.

I think this is -- I think I should explain that the person sitting next to me has been writing a lot of these letters all through the '80s and '90s and she says, and it's worth reminding us, what is the first priority? To build up enough resources to stop having imported blood. That was more important than prophylaxis in my view and that's why I didn't change that departmental thing, knowing it would cost anyhow money I was straining the tolerance of the Department overall commitment to this programme. They weren't going to be driven at that stage by the haemophilial experts. But, like any department, the documents we tried to give them what they want for their patients and we did eventually accept prophylaxis.

Q. If clinicians using prophylaxis was potentially going to impact upon the ability to achieve the pledge of self-sufficiency that the Department was working

towards, which was home treatment but not prophylaxis, it might have been sensible to take steps to --

A. Yes. What was the first priority, which was to avoid -- you wanted to use AHG concentrate. You wanted to treat people at home and this is another issue, which is to try to avoid children having to go into hospital, which was another policy which we were pursuing, and to wherever possible keep them at home in their family environment.

This time I had children much the same age and you were wanting all the time to bring home treatment up. So that that was a higher priority than the best safest, which was the cryo.

Now, you come into a third policy, which is even better than home treatment, and that is to have a level of factor X in the blood that they never bleed. But that was going to require huge amounts of extra blood, much of it would be, on present policies, would be more and more relying on imported blood and infected blood. So you were balancing these priorities -- not easy -- but again the Department was absolutely solidly with us, the medical advice was solidly with us. We stuck to it at that particular time.

Q. Do you know whether any steps were taken within the

Department, or perhaps by the Chief Medical Officer to, try and communicate to the Haemophilia Centre Directors who might be using prophylactic treatment that that wasn't what the policy was about?

A. This is a tricky question. The CMO is the one to do that. I don't know what he was doing at that stage. I'm sure that they were using their advice and that's one of the reasons that they didn't want me to say it. Let's tell them that -- the only person who can really override clinical freedom is the CMO or his deputy, Bob Reid, who was dealing with this issue and I think Dr Yellowlees would have taken -- re this, he would write a letter on this issue in his name but it would basically be dependent on Reid's advice and he would be weighing all these factors, overriding the freedom of a haemophiliac doctor to do what they think is in the best interest of patients is very tricky.

It is done from time to time but as far as possible it's advice to doctors. It's pretty rare for a Chief Medical Officer to issue an edict but he does have the authority to do so.

It is accepted within the profession he consults the Royal College of Physicians, the Royal College of Surgeons, and everything like this.

I think it's helpful for people to understand

how these decisions are taken. What's important is that the Department is entirely behind the policy, though constantly warning about the cost.

Out in the sticks, the haemophiliac doctor is trying to do the best for his patient and, on that scale of priorities, prophylaxis is the best of all. But it's hugely costly because it requires so much blood and it really was a policy that was better introduced, as it broadly was, as we got less and less dependent or worried about commercial supplies because of heat treatment for hepatitis.

Even then, you see, the self-sufficiency was not because down the track was AIDS and HIV virus.

MS RICHARDS: Sir, I note the time. Is that a convenient point to stop?

SIR BRIAN LANGSTAFF: Yes, it is. We'll take a break now for an hour. The usual provisions apply as applied last time. You have allocated seats, I believe. Please use them and I look forward to seeing you back here. It will be at 2.05.

(1.06 pm)

(Luncheon Adjournment)

(2.04 pm)

MS RICHARDS: Lord Owen, there's a further progress report that you received in October 1975, and we'll just look

at that briefly.

Henry, it's LDOW0000023 -- oh, and there it is. Thank you.

So, again, we don't need to go through it paragraph by paragraph but we can see from the first paragraph that it's a response to a request for information, an update about the position of the centrifuges in the two regions. You are then told the position in the next paragraph about the centrifuges. You are told the position in paragraphs 3 and 4 about the regions.

And then if we could go to paragraph 5 -- please, Henry -- we can see that you are told that the current position, as at 23 October '75, which is the date of this:

"After a series of written and oral exchanges over the past few months, both regions have now given us reasonably satisfactory assurances that they can and will meet the targets which we originally set them and with only minor modification on the financial terms we first offered. We are now, therefore, in the position that all regions have agreed to take part in the programme. Satisfactory though this is in itself, it is no guarantee that things will run smoothly and it will be necessary to monitor development closely.

Arrangements have already been made for this to be done."

Then if we go to the very top of the page, we can see top right-hand corner is your handwritten note. I think, again, that's your handwriting. Happily, I also have a typed version of it:

"Good, my congratulations too. I attach a lot of importance to keeping to and, if possible, improving on our present target."

Is this a further example of what you described as your role as minister, as the politician, was to try to ensure that the pledge that you had made to Parliament the previous year was being delivered?

A. Yes.

Q. If there were problems, if it wasn't going to be possible to achieve self-sufficiency within the target of the two to three years, would you have expected your officials to be reporting that to you candidly?

A. Yes.

Q. We know, and indeed you have already referred to it, that in December 1975 there was the World in Action documentary broadcast. We're going to watch that tomorrow so I won't play it now, but I wanted to ask you to look at the transcript and just ask you to deal with one point.

Henry, the transcript is at LDOW0000039, please.

I am not going to ask you about what you said because we have it there, as it were, on the record but if you could go to page 16, Henry, please, I wanted to draw your attention to a point that was being made by Dr Watt, the Scottish National Blood Transfusion Service.

So it should be page 16, please, Henry.

So we can see, about a third of the way down we have "Edinburgh exterior", and we have the voice-over referring to Factor VIII concentrate being made at the plant in Edinburgh:

"This plant is designed to produce Factor VIII concentrate for England as well as Scotland but so far no plasma has been sent here for processing from England."

Then there was a reference to John Watt, and we see what John Watt said:

"We should be able, at our capacity, to more than produce the need of all plasma fractions, for Scotland certainly, by spring of next year. After that it will depend on the policy arrangements which have to be made between the Scottish Health Service and the National Health Service, the Department of Health and Social Security."

The question is then asked:

"But if plasma was made available from England and Wales now, could you actually produce more Factor VIII concentrate than you are doing?

"Answer: Yes.

"Question: How much more would you be able to produce?

"Answer: We could go to a capacity of 1,000 litres a week.

"Question: Would that in fact supply the demand of all the haemophiliacs in Britain?

"Answer: No.

"Question: What sort of proportion would it supply?

"Answer: A difficult question to answer. It would probably be around half, a little more than half, perhaps."

Then the comment from the journalist is:

"English plasma could be processed in Scotland now, but only if present policy is reversed. This rules that Edinburgh will not be used until Elstree reaches maximum output in 1977."

Do you know whether it's correct that the policy was that plasma from England and Wales wouldn't be sent to Edinburgh until Elstree reached maximum output

in 1977?

A. Well, from documentation which I saw recently we had a meeting on this in the next year, in '76, in which -- that was a meeting about this American company that wanted to be able to supply and in the context of that meeting it's minuted that I raised a question of greater co-operation between Scotland and England and asked them to convene a meeting, which they did. And I think you have the result of that meeting.

If you look carefully through it, it doesn't really grapple with this issue. And I don't know what happened thereafter but pretty soon after that I was no longer the Minister of Health and was in the Foreign Office.

Q. Were you aware, as Minister, of any policy or edict along the lines that is suggested here, that plasma from England and Wales couldn't be sent to Edinburgh until Elstree had reached its maximum output? Was that something brought to your attention as far as you can recall?

A. It can only be inferred by the fact that I asked them to hold the meeting, which is pretty unusual, that I was not satisfied. But I can't really say more than that. All I know is, reading the minutes,

I don't think it felt to be satisfied and then, as I already told you about, the article in the BMJ, which is a pretty strong attack on the mechanism of working in the delivery of the transfusion service in the UK.

Q. Yes, I should say, the Cash article to which you refer is much later in the sequence. It's 1987 I think but --

A. The Cash article I think was 1980, wasn't it?

Q. I'll double-check the position.

A. Yes. The only other thing I did was -- is this involvement of Brian Abel-Smith, which was to try and see if he could look at the structures of how this was working, which I think he did.

Q. It's certainly right there are two meetings in 1976 where the question of Scottish/English co-operation is touched on, and we'll look at those. The first is the one you have mentioned.

Henry, could we have DHSC0003742_076.

If we could just -- thank you very much.

So we can see it's a meeting of 21 January 1976. We can see that you are present. And paragraph 1:

"The meeting had been called at Dr Owen's request following his consideration of a submission ..."

We don't, sadly, have the submission, but we'll come on to the documents later:

"... about an application from Armour Pharmaceutical Company to supply Factor VIII to haemophilia centres."

Now, just pausing there, what involvement did you generally have in the time you were minister with applications from pharmaceutical companies of this kind?

A. Normally a supply contract would not come to me, and it says, at the top of -- the meeting:

"The meeting had been called at Dr Owen's request following his consideration of a submission about an application from Armour Pharmaceutical Company to supply Factor VIII to haemophilia centres."

So I'd obviously seen this and requested the meeting. So we were looking at the fact that they were cheaper, why were they cheaper, and -- quite a big difference. But then it's clear that they had some technical problems with it. So it wasn't necessarily going ahead.

Q. If we look further down the page, Henry, if we could go further down, we can see in the bottom part of the page there's a discussion about the quality of the products from Elstree, they are said to be inferior to

the Scottish product. And you asked that the Scottish laboratory and Elstree get together to discuss processes and share technology, and you asked for a progress report?

A. Yes, within a month.

Q. But that's a slightly different issue, I think, to the issue thrown up by the World in Action programme. This is talking about was Elstree's product good enough and could it be made better.

A. Yes.

Q. Just in terms of your dealings with the Armour submission -- and again, I appreciate you are hampered by the fact that we don't have the submission itself that apparently triggered your desire for a meeting, but if we go to the very top of the page, the subject is "Factor VIII product licence".

A. Yes.

Q. Again, it may be that you can deal with this matter generally. Generally speaking, as Minister, did you have any involvement in the product licensing process?

A. Not normally. But if there was a problem, and I suppose they would say this was politically sensitive, which it certainly was, but I doubt I would have -- I could stop it if there was -- I mean, we were governed here by trade agreements between the

United States and Britain. You don't have a ministerial selectivity over this but if they are in breach of the proper standards, and solubility was one of them, you could stop that.

On the other hand, you couldn't just stop it because it was a contract, and particularly since you weren't giving them any guarantees -- far from it. You were reiterating at the bottom of this letter a statement that they should understand that we were abiding or trying to abide under the injunction from the WHO, which was sent to all departments of health all round the world, to do your best to get away from having -- paying for donors and relying on commercial blood supplies, which we certainly were.

So we were effectively telling Armour: the mere fact you've been allowed to bid for this, and even the fact that you are a lower cost, is going to be overridden by our overall commitment to follow the WHO criteria, which I strongly approved of.

Q. If we can go to the second page, please, Henry, just so we can see what Lord Owen is referring to.

The minute records:

"Dr Owen agreed that negotiations could start with Armour Pharmaceutical but he asked that it should be spelt out that the overall policy of the British

Government was in line with the WHO recommendation to aim for self-sufficiency."

What was the purpose of spelling that out to Armour?

A. To indicate to them there's no good coming back and saying, "You've just recently agreed that we can come in and you never mentioned the fact that you were ultimately coming to a point where you would actually say you can no longer supply blood."

So it was, I would think, no more than fair practice and honest dealing. You were authorising it but they had to understand that it could be stopped at any moment we were self-sufficient.

Q. Then there's a second meeting, in March 1976, on a different topic but again it deals with the question of and Scotland co-operating.

Henry, it's CBLA0000343, please.

We can see from the attendees -- we see the date, 11 March 1976, and then we can see from the attendees that it involves representatives both from Oxford and Elstree, and obviously the Department, but also from the Scottish National Blood Transfusion Service, the Scottish Home and Health Department and PFC Edinburgh.

If we go to the second page, please, Henry, we

can see the first paragraph says:

"The Chairman opened the meeting by explaining that the Minister of State who was taking a particular interest in the production of Factor VIII within the NHS had recently reaffirmed the intention to achieve NHS self-sufficiency by the middle of 1977. He was anxious that there should be maximum co-operation between the production units in England and Scotland both in achieving the target figure and reversing any preference which some users might have for one or more commercial products."

It would appear you've communicated to your officials your desire to ensure -- it may or may not have been triggered by the World in Action programme, I don't know, but your desire to ensure proper co-operation between England and Edinburgh, and this meeting is a result of that?

If we look at the second paragraph --

A. I didn't quite understand that. Can you speak up a little bit.

Q. I'm so sorry, Lord Owen, yes.

It would appear from the first paragraph that you have indicated to your officials your desire that there should be maximum co-operation between England and Scotland. I don't know whether that was prompted

by the World in Action programme or whether you are able to recall that or not.

A. I don't think it was prompted by the World in Action programme because there wasn't much in the World in Action programme that was news to me and, indeed, I don't think it was to anybody who had read Titmuss' book there was much there that was not known. It was why I welcomed it because it was giving it much wider, you know, millions of people watched that television programme and it gave it a much greater prominence why we were concerned, why the logic for self-sufficiency and they were able to spell it out in ways I couldn't do. That's why I welcomed the programme.

I mean, they were running risks of libellous allegations, if you look really. They were saying some pretty tough things about the skid row and the way there were no safeguards at all in commercial products and this was a big company. It was Baxter, which is a big American company. It was a brave programme.

Q. The second paragraph of this, the notes of this meeting if we just look at the very last sentence, please. It says:

"Dr Maycock drew attention to the fact that the UK target was set by the expert group on the treatment

of haemophilia in March 1973 and that there were those who now thought that the target should be considerably higher."

Do you know whether you were told that it was being said by Dr Maycock that the target should perhaps be higher or that some --

A. Well, it already was by then, in '76 we already knew we were on target to produce a good deal higher than what we had said in 1975, and that's what happened. In '76 and '77 we surpassed the commitment. I do think this is pretty important to realise that we didn't just meet the targets, we surpassed them. That wasn't my effort, that was the Department and all these people who were cajoling, cajoling Scotland, cajoling the regional transfusion units, who considered themselves independent. I mean, that was one of the problems. That's the delicately phrased thing about some who would prefer to go on taking commercial products even when there was this increased production.

So I mean, that's a delicate way of saying that we had to pressurise them to take account of what was already underway and deliverable so we were already able to cut back but there was this rising curve coming up, so we knew that we'd have to go on doing

it, and that's the whole question of recurrent expenditure. There was no doubt. I don't know when budgets were fixed but we were well aware that we would have to spend more, hopefully not too much more, and that's why Scotland was important because they already had the capital equipment, so if you could get them to increase their production and that was the most obvious logical way to have a quick gearing-up.

Q. In April of that year, 1976, 29 April, you addressed the World Federation of Haemophilia. I think we can see that from LDOW0000044, please, Henry. We've got the text of your speech but this is a press release from the Department of Health and Social Security.

We can see here:

"UK aims to be self-sufficient in supply of blood products. Dr David Owen today strongly supported the World Health Organisation policy that each country should be able to supply its own blood and blood products to meet clinical needs. He told the World Federation of Haemophilia Congress at the Tara Hotel London that the NHS was not at present able to provide sufficient Factor VIII concentrate needed by haemophiliacs for the management of bleeding and health authorities were having to buy expensive imported products. Following a special allocation of

£500,000 last year substantial progress was now being made in building up production capacity in the NHS and self-sufficiency in home-produced Factor VIII was expected to be reached in mid-1977."

A. This isn't on our screen.

Q. I'm so sorry.

A. I've read it so I do remember it but ...

Q. I can ask the question I want to ask about this document without you seeing it but we will need to rectify that for a handful of further documents.

SIR BRIAN LANGSTAFF: I think we just need to check that there's nothing gone wrong with the link because it is on all the other screens that I can see.

If you would be so kind, Lord Owen, just to bear with us while the technician checks. *(Pause)*

A. I've really got a short extract of what I said at the conference.

Q. I can ask the question I want to ask I think without reference to the document. The document, in a sense, was for the benefit of others.

You were saying then your expectation was that self-sufficiency would be reached in mid-1977?

A. Yes.

Q. And that was presumably based upon the information, the progress reports that you were being provided by

your officials?

A. Right, and that speech would be -- it was a formal speech so it would have been seen in the department, been checked against delivery. It was one that was going out internationally endorsing the World Health Organisation, so I think you can be absolutely certain this was not just my whim, it was the view of the Department having had all these discussions, having monitored the process of all the machinery that was necessary, what was going wrong in Elstree, and also taking possibly some account of maybe more co-operation over Scotland.

Q. Then again just continuing with 1976, you left your post as Minister of State for Health on 10 September 1976 and moved to the Foreign and Commonwealth Office?

A. Mmm.

Q. I think --

A. It's come up now.

Q. Good.

I think the answer to this may be obvious from what you've just said but it's an important question so I'm going to ask it again.

When you left office, did you understand the target of self-sufficiency to be within sight?

A. Yes, '77, definitely.

Q. Your successor was Roland Moyle?

A. Yes.

Q. David Ennals had taken over from Barbara Castle in April of that year as Secretary of State for Health. I don't know what the process in Government was but would there have been any or were there any handover discussions or any communications on this issue between you and your successor?

A. Well, I knew him and liked him and respected him. It was not really necessary to have discussions because the continuity came from the private office, the people who were running the private office I think continued for some period of time and that's, you know, why private office records are kept and why it's such an extraordinary thing to find the whole of my private office records were pulped.

So the record, because the private office was driving this programme, I mean, let's be blunt about it, that's what was happening, so the documentation in the private office which he would inherit was part of the continuing pledge.

Q. Now, we know from the documentation that we've looked at that the £500,000 was spent on regional transfusion centres to improve the plasma supply. Other than --

SIR BRIAN LANGSTAFF: And I think on three centrifuges for BPL.

MS RICHARDS: Yes, just about to come to that, sir.

Other than provision of centrifuges to BPL I think it is right none of the £500,000 was earmarked for any work on BPL?

A. I don't know the answer to that question. You would have to look -- various documentation split this up as to what was going to be happened but if it was necessary for BPL it would have been put there by officials.

Q. We do know that -- and this is after you left office -- but towards the end of the 1970s and in the early part of the 1980s BPL was effectively condemned and had to have substantial works undertaken to it.

Was that something, the potential rebuilding or significant investment in BPL, was that something that was ever discussed with you by officials?

A. Of course. BPL came up all the time as trying to be a factor in expanding production. But again I reiterate: it was done.

I mean, where's the figures from Roland Moyle answering questions in '78 or '79 showing, the figures for '75, '76 and '77 all show that this policy was being followed. If I may say so, I do find it really

quite extraordinary that there can be this attempt to try and pretend in 2001 when they are asking a question for Lord Hunt the same thing, that the only reason we're going to self-sufficiency was cost. I mean, that is a blatant lie and I don't understand how that could have been put through the Department. The Department knows perfectly well -- maybe it was just a briefing by a SPAD, these political advisers that have come in since my day.

I don't know but it is an absolutely monstrous accusation and it can't be allowed to go unchallenged. It is absolutely clear that the reason for self-sufficiency was the contamination of blood in products coming in but products that were needed for patients' care and we couldn't suddenly stop it without a disastrous effect on them. But we had to put every possible effort into getting the self-sufficiency as quickly as possible.

Maybe it would slip a little through no fault of anybody's but it can't be allowed to slip well into the '80s and even when you got the heat, that didn't solve the problems because there were other issues and there you go into HIV, of which -- well, to a great extent this is outside my service but self-sufficiency was not related purely and simply to Factor VIII.

Self-sufficiency was a reading of what's going to happen in the future with other infections that we will not be able diagnose and that we will have to live with contaminating patients unless we can do something.

But, you know, British blood taken with the best will in the world you can't tell every single person when asked whether you've ever been yellow answered that one truthfully, but it was much more less likely, put it that way. But all blood is in risk of contamination.

Q. Lord Owen, you have touched on this in your evidence already about the way in which the Regional Transfusion Centres and the Regional Health Authorities were effectively autonomous. Was consideration ever given whilst you were Minister of State to the possibility of centralising the blood transfusion collection system rather than having this fragmented localised system?

A. Well, all I have in front of me is this very short letter to ask Brian Abel-Smith to look at this. I am pretty sure that was in my mind but I can't, to be honest, say definitely it was. But it was a hot potato to do with it and during the initial thing I don't think I wanted to rock the boat

organisationally. I wanted the best commitment possible out of them all and I was relying on the Department of Health officials to do it, and I think they did it and I think they did a fine job. You will notice quite often I said excellent, and when we were lagging behind they caught up, and when they themselves reported on various items of equipment which were absolutely crucial and were watching it like hawks because they knew I was watching it like a hawk. But they were committed to it. These are good and honest people conducting a policy at a time of very great difficulty in financials.

You know, the spending years were over by then. We were facing a very difficult economic situation, so we knew we would have to rely on our own resources squeezing other parts of the department to get this through and they were committed.

I thought I should mention just while I'm on that subject I don't know whether -- it must be in your files but there is a dear doctor letter from Henry Yellowlees which is dated 1 May 1975 which does go into the geographical factors behind hepatitis.

Q. I have it.

A. You are aware of it, are you?

Q. Yes.

A. Are you going to ask me about it?

Q. I wasn't specifically going to ask you about it, Lord Owen, but it is a document we are going to be looking at tomorrow.

A. It does reveal the sort of way in which the Chief Medical Officer brings together all the facts and then gives I suppose you could still call it advice but it's pretty much an instruction.

Q. Thank you for raising it and it is a document that the Inquiry has.

I wanted to just play a short extract from the 1980 documentary "Blood Business" in which you gave a short interview, so it's after you've left office but you were interviewed about the issues that we've been discussing.

Henry, it's MDIA0000109, I think.

(Extract of video played)

I just wanted to show you that and just ask you a little more about the question of demand. Again your evidence has already touched on it.

What system was there in place in the Department to gather information and to work out how demand was likely to increase in the future?

A. Well, there was this advisory committee which the Chief Medical Officer conducted and you drew attention

to it when, right back in George Godber's time when he asked Dr Bridges whether she would come on the advisory group. So there was a constant monitoring of this demand, and then as we said in earlier questions, there were those who thought self-sufficiency included prophylactic use. The Department didn't accept that at this stage. There was a difference openly acknowledged.

But everybody who's in their own specialty can come before the Minister of Health and ask for more money and have a perfectly rational good case for it, for which I would agree. The question is priorities and that's Aneurin Bevan's famous phrase "language of priorities, language of politics". You have to make choices. They are not easy, and particularly when financial times are not good.

The Health Service is like that. But overall I'm a strong believer that in the National Health Service, the whole system, doctors are given a real say in priorities and trying to choose it, the voice of the individual GP, the clinician, is heard within the system and compromises have to be made and effectively it's rationed but it's rationed on a pretty enlightened system where individual doctors can say what that doctor said, powerfully and believes

it, but it could be matched by a renal surgeon or a dialysis unit, so you have to choose.

I think we made the right choices in '75 and '76 -- obviously I do. I think that somewhere, which is your job to find out, when did the money itself start to limit it? I'm not sure where that is to be honest. I don't know.

Q. Before we look at events after you were Minister, one last question about your time as Minister.

I don't know whether you will be able to answer it or not, Lord Owen, but with the benefit of hindsight, with the benefit now of the full hindsight that you have, do you think there is more than could or should have been done in that period 1974 to 1976 and, if so, what?

A. Well, you ask the question in a way that's very difficult to answer. More that could have been or should have been done? More could have been done. You could have put vast resources -- the 20 million that the doctor wanted in 1980. You weren't going to get 20 million for it in 1980, and you certainly wouldn't have been able to get it before.

We started on an investment programme. We made a public pledge. We fulfilled those requirements and our targets over and above which we'd anticipated.

Fortunately, because demand was increasing.

I don't know -- I hate it -- I hate the saying, "There wasn't anything more we could have done"; there's always more you could do. But you've got some idea of the resistance to this policy, this choice. I think we did. And I don't -- I don't say me, I believe the Department understood that we had made the right decision, they backed it and they stayed with it. And many of those people were staying on in office long after I left. So I believe that, collegiately, we made the right decisions.

Q. You remained in Government until obviously the election of 1979 but not in the Ministry of Health. Do you recall any further discussions within the Government that you were privy to on this issue?

A. Well, the Foreign Secretary is travelling around the world quite a lot. I can't -- I didn't attend even every Cabinet meeting, I was in Africa negotiating and in a lot of other places. But I don't think -- I did try to come back for the main Economic Committee, which I was also on. I can't recollect it ever coming into Cabinet or to the main Economic Committee and it wouldn't really, it would be dealt with internally within the Department in their own resources. This was not -- it was not a controversial decision. It

was never criticised outside Government. Even the Treasury never, to my knowledge, singled out this as a wrong decision. Because they'd often criticise in the yearly budget reviews, "Well, you've spent money there, you've spent money there", and it would come back to me, through Mr Gidden and others, saying the Treasury are very unhappy about spending this there. They took views on our priorities. I don't think they ever challenged this priority while I was there.

Q. I'm just going to ask you a little about some of the subsequent statements made by Government ministers that you've referred to in your witness statement. I'm going to pick it up, first of all, in June 1978.

Henry, it's RLIT0000272.

We can see -- you see the date there, Lord Owen, and you'll see the question that's posed of the Secretary of State, referring back to ministerial statements made by you, whether the self-sufficiency has been achieved, and if not, asking for an explanation of the reasons.

Then we can see the answer from Mr Moyle:

"The production target of Factor VIII set for June 1977 was attained; however, new opportunities in the treatment of haemophilia and associated disabilities have been developed which have made

further clinical demands for Factor VIII."

Then the question is asked, how much of that £500,000 had been allocated, and the answer is:

"The whole sum was used to increase Factor VIII concentrate production within the National Health Service."

Then we can skip over the next question, Henry.

There's then a question of what the current shortfall is and what action is being taken and Mr Moyle says:

"Current amount of Factor VIII is approximately 30 million international units per annum. Total usage is estimated to be approximately 45 million international units. Regions are being asked to provide more fresh frozen plasma. In the meantime, quantities of commercial Factor VIII continue to be purchased to meet clinical demands."

Then the question is asked:

"What additional central funding has been allocated to the Blood Transfusion Service to improve blood fractionation?"

And the answer there is:

"For 1978 to 1979, a total of 145,000 had been allocated to the central processing laboratories in England to enable them to increase the production of

blood products, mainly of Factor VIII concentrate."

So we can see that the £500,000 that you had -- your word -- pledged has been spent on the purpose for which it had been pledged?

A. And achieved the purpose for which it was --

Q. But self-sufficiency itself not achieved, for the reasons here outlined by Mr Moyle?

A. No, but if -- these are historic costs, historic figures. It may be that it been answered it in '78/'79, they are going on now into different financial years. But for the years that were ahead they fulfilled their criteria and they expanded it. So I don't -- it's not for me to say but, just looking at those figures, it doesn't appear to me that self-sufficiency has run into a brick wall at this juncture in '78/'79. They're still putting money into it.

Q. I think if we then look at RLIT000026, this is later in 1978, end of 1978. The question is if the Secretary of State will make a statement on his success in rendering the NHS self-sufficient in the provision of freeze-dried Factor VIII.

And then Mr Moyle answers, gives information about the estimated need and the rate of production, and then says this:

"The extension of clinical requirements however means that self-sufficiency has not yet been achieved and my Department is therefore reviewing production in relation to present demands and resources."

A. Well, again, unpredicted projections forward have largely been met because we expect over -- we overproduced, if you like, what we wanted to produce. So it was a running target and he accepts this and he wants to apply more resources to it. That seems to me that -- my reading of this. He says:

"... self-sufficiency has not yet been achieved and [it] is therefore reviewing production in relation to present demands and resources."

He seems to be on-side for the pledge at the moment. I don't see any reason to go back and say, "We're not on track". But, you know, it's a moving target, and you're starting getting these elements. It would be interesting to know how much was being put on prophylactic use, whether it was just a small amount. I suspect a rather small amount.

Q. If we then move on to December 1980 -- so this is the new Government -- it's RLIT0000268, please, Henry -- and again, you have referred to this in your statement.

A. This was a debate, wasn't it?

Q. Yes.

A. A German debate.

Q. That's correct, Lord Owen.

If we go to page 5, we'll see who's speaking: the Under-Secretary of State for Health and Social Security, Sir George Young.

And then if we go on to page 9, please, at the very bottom of the page it says:

"The motion also refers to the declaration of the 28th World Health Assembly, utilisation and supply of human blood and blood products, which in essence urged WHO Member States to try to be self-sufficient in blood and blood products. The Honourable Gentleman referred to that the principle of self-sufficiency is one that the Government fully endorse, quite apart from the possible risk of hepatitis from imported products, particularly those manufactured from plasma made by paid donors. The very fact that products are imported unless they come from a country that produces an excess of such products raises difficult moral issues concerning trade in blood. But self-sufficiency must inevitably be a long-term aim."

Do you regard that as the same pledge or a dilution or change in the pledge?

A. I read the entire speech of the Minister and I must

confess I thought it was a pretty good statement. He also made a lot of criticisms of relying on markets and commercial -- he seemed to be on side for self-sufficiency, a long-term project.

Well, he's right, isn't he? I mean, you know, self-sufficiency is driven by all the time trying to find contamination and developing techniques to get rid of it. So somebody must have been starting to working -- I mean, the whole antibody assays and things were fairly new science.

I mean, the HIV virus was detected by its antibody, not by heat treatment. So heat treatment wasn't getting rid of it, it was the finding an antibody titer I think is the main -- you have taken me outside my realm of expertise in terms of a minister but just as a general interest in it all. I think that -- it's not my job to defend the Minister. He's not even of the same party as mine but I don't read that speech as somebody who is disowning all the policy of the previous Government.

SIR BRIAN LANGSTAFF: I think what you have been asked to do is to contrast his statement that it's a long-term aim from your view that self-sufficiency, not simply the spending £500,000, but self-sufficiency could be achieved within two to three years and was going to be

achieved by 1977.

Here is the Health Minister saying some years later that it is now a long-term aim, by which I take it he's not putting a figure or two to three years on it.

A. Yes.

SIR BRIAN LANGSTAFF: So that's what I think you are being invited to comment on.

A. Maybe.

SIR BRIAN LANGSTAFF: What is your view?

A. I don't like the -- well, one word "long-term". I'm rather against trying to finger other people and try to blame other people and to read into their speeches things that I do not know.

I only know what I did and I -- I don't think I'd have used that word because it has the implications of your question behind it. Maybe that was -- I have to say that that speech was taken by Mr Cash in his British Medical Journal attack on the Blood Transfusion Service and said that by the early '80s the Government were talking the language of self-sufficiency but weren't supporting it and he said despite the speech made in the adjournment debate.

So he cited is that as being language which was all right but was not being matched by commitments.

I don't know. I even won't get too much into getting into Mr Cash's -- but he was the head of the Scottish Transfusion Service and it was meant to be a helpful, though critical editorial. It wasn't totally damaging. He just felt he ought to speak out about it.

So I think that we were talking about self-sufficiency of not relying on commercial donors. That's where we were really -- we were self-sufficient in blood for British use, believing we could get enough donations and enough fractionation and enough quality products to keep pace with demand.

But the demand was coming from clinicians and here the big unforeseen factor was prophylactic use which, as I said earlier, was later accepted as being a legitimate demand. But there was this difference of opinion in the Department when I was setting the self-sufficiency limit. That then later incorporated prophylactic use, and I'm not saying it shouldn't either.

MS RICHARDS: Lord Owen, Henry, if we could have on screen RLIT0000267, this is a statement by Kenneth Clarke that you have already referred to so it would be useful to see it on screen. This is a question asked of Mr Clarke on 19 February 1985, what studies the

National Blood Transfusion Service has undertaken into the economics of self-sufficiency in Factor VIII and if the results are to be published.

The answer is:

"We decided in 1982 that this country should become self-sufficient in blood products."

You have referred also -- I won't take time going to it but you have provided the Inquiry with it and it's exhibited to your statement -- you received a letter from Baroness Trumpington which effectively said the same thing.

A. Well, that's the year when I began to get worried about what we were doing. I mean, Hancock I knew well so I probably had some involvement in the question.

Q. You've expressed a degree of puzzlement in your statement as to how it could be the Government were saying in 1984 that that was a decision taken in '82.

A. Well, a minister, a junior minister in the Government of which he was a member, two years earlier had said they were in favour of self-sufficiency and he's now saying we decided in 1982 that we should become self-sufficient. The two -- the adjournment debate response and this are not compatible.

Q. This was -- this in due course I think became part of the basis for your complaint to the Ombudsman in 1988.

A. Yes. Did it?
Q. Well, perhaps you could summarise, Lord Owen, rather than me attempting to do it what your complaint to the Ombudsman was in 1988.
A. Well, I think it was a cumulative argument about maladministration. I mean, the Ombudsman was set up with great fanfare of publicity and it was considered a great opening up of healthcare to scrutiny and MPs, instead of relying on questions and answers, could get a maladministration looked at in the round within this Ombudsman principle. Ombudsman is a foreign word. It was greatly enthusiastically accepted by Members of Parliament as a big advance. I think it was Dick Crossman who did it. I can't remember now.

Slowly, now in retrospect, even in legislative form, we narrowed the terms of reference because governments don't like being scrutinised, to be honest about it, by and large. First of all, it's difficult to prove in a letter but I tried to get them to focus on the fact that there's no one decision that was involved here. It was cumulative decision-making and that you can only really get at that by an inquiry from within who are looking at the documentation. You don't expose that in Parliamentary questions or adjournment debates. So it seemed to me absolutely

tailor-made for the Ombudsman.

The first thing that was done is you had to have an individual case that you had to be able to represent, so I approached the Haemophilia Society, which I've always found to be very good, you know. I am sure they are critical of some things I did but, I mean, that doesn't matter. They were trying to be a representative voice for haemophiliacs and, in my view, have done sterling work over many decades.

They approached privately a person in my constituency who was a haemophiliac and had actually caught AIDS, was suffering from AIDS, and I went to see him and he agreed that I could use his case and preserve his secrecy, which I did. It's not always easy, these things.

So I met the criteria on that issue. So then we find that they still wouldn't investigate it. Then I tried to revive the case and this was the time I couldn't revive the case because I was now a peer and it could only be done by a Member of Parliament, in the House of Commons.

Well, I'm a strong supporter of the House of Commons and not a great supporter of the House of Lords. It is an appointed chamber, so I can't say I was terribly upset about that. It is more important

that Members of the House of Commons have it. But it certainly was not prepared to accept maladministration.

If I look back on this, I don't personally think there's been evil men or bad decision-making consciously. I think there has been a general maladministration of this issue over a long period of time and I think it was an absolutely classic case that should have been exposed by the Ombudsman system.

Well, it didn't do it and I hope in your recommendations, sir, you will look at this and Parliament should, in my view, re-legislate for it because I think that the ombudsman is a good system, when dealing with such a complex question as healthcare particularly.
Q. Just so that those who are listening understand the particular issue that you had raised with the Ombudsman, there's a whole chain of correspondence and I won't go through all of it. You have provided it all to the Inquiry and it's been disclosed, but you have said this:

"The crucial commitment to become self-sufficient in blood products was made when I was Minister for Health, a commitment made after careful consideration and quite a bureaucratic battle, in

order to avoid the necessity for imported blood products. I am appalled that this commitment was never secured. As a result, infected blood has been introduced long after it need have been."

Then I think in your subsequent correspondence you raised the point with the Ombudsman about no minister had come back to Parliament to say if it was no longer the policy that that was the case.
A. Yes.
Q. And you could not persuade the Ombudsman to even initiate an investigation?
A. No. Not only that, requests took months to answer and then they claimed to have lost the files and that they couldn't go back over the previous correspondence, even if that's just that they are not invested enough to keep proper records. It was a pretty extraordinary situation.
Q. I wanted to deal next with the issue of the loss of records relating to your time in office. Again, you have alluded to this already in your evidence. Your private ministerial papers, your private office papers, first of all, could you just give us a brief idea of what those papers would include. What kind of material would be in there?
A. Well, to be frank, I only really know more about what

of my private papers when I was Foreign Secretary because they are in my possession and they are in my possession but I've given them to Liverpool University so are part of the archives in Liverpool University.

By and large, they are things which the private office think are personal to the Minister where the ministers leading the discussions are not just necessarily making policy and something that is interested in sufficiently to want to keep it. There's a selectivity going on mainly by your private secretaries and sometimes you say, "for my private files, for my private thing", because you know that you want to keep it.

But in this case it wasn't just this. This wasn't the culling which Lord Jenkin mentioned of the papers. He calls it a cull of his own papers and I don't know how much he lost of his own departmental -- of his private office papers. I lost the whole lot. So it's nothing to do with everything else that was going on and a great deal was going on, you know. Smallpox eradication programme. These are the sort of little things that come. They ran out of money.

The Chief Medical Officer came to see me with tears in his eyes saying, "I need an extra 2 million

to keep the teams in the Ethiopian mountains". I said, "Fine". He said, "How do you get the money?" I said, "I'll just take it from something else". That's what you can do as a minister. Now, that is something which would go in my private files, smallpox, you know, it would just be there and you don't find that now because there are no papers left now. I just don't know what happened and draw a distinction between this and what was then done in culling relating to, first, haemophilia and, secondly, AIDS.

So this was before AIDS, nothing to do with the various admitted in Lord Crisp's evidence, and there incidentally they talk about that this culling took place in early 1990s, mid-1990s, late 1990s. So it's a pretty extraordinary span. But mine are different. Mine are just my whole papers were taken out in -- we think in '88.

Q. You've produced and exhibited to your witness statement a document at LDOW0000318.

No, that's not it. LDOW0000318.

So this is an exhibit to your witness statement, Lord Owen. It says:

"DHSS records. Papers have been destroyed. Normal procedure after ten years."

As I understand it, this is not a DHSS note, this was a note made by someone in your constituency office?

A. In my private office at the time there were probably four or five people working for me, and this person was dealing with constituency letters and that suggested -- her handwriting, saying -- reporting on a telephone conversation she must have had with the Department, saying that, "I wanted to make an appointment for Lord Owen to come and see his private office documents and was told that the papers had been destroyed, normal procedure after ten years."

Well, since then we've told that there isn't any normal procedure for doing it after ten years. Remember that in those days I think the 30-year rule was still applying, that you couldn't divulge your own private documents without permission in certain key areas. Then it was 20 years and now it's not really a fixed-year period. But they say there was never a ten-year period. But she was a very reliable person and I'm sure that is an accurate account of what she was told. And so there was no papers for me to go and see.

And we think it's in the constituency section because the person I was told to go to the Ombudsman,

I had to have a constituent, that he -- she was dealing with correspondence with him because he was a constituent, and that makes us think it's very definitely towards the end of 1988 -- sorry, towards the beginning of 1988.

Q. Indeed, that's when you were making your complaint to the Ombudsman in February 1988. And at some point in the sequence of correspondence with the Ombudsman you relate to him that you've just recently learnt that your private papers had been lost or destroyed?

A. Yes, I think I did.

Q. Just to be clear, your private office papers from your other ministerial posts at the Foreign and Commonwealth Office you have?

A. Yes.

Q. They're in the archive that you've referred to in Liverpool?

A. Yes, some go to the National Archive and some are just over and -- they've got no use for them and they asked me whether I wanted them and they were totally delighted to take them all, give them all, and they were pushed up to Liverpool.

Q. The second document that you have exhibited to your witness statement on this issue is at LDOW0000350.

I say "on this issue", it's on the question of

documentation more broadly.

You will see this is a memo dated 15 December 2003. Your name is at the top and it's "MS8", so the then Minister of State for Health had asked for:

"... a full background note on the review of internal papers between 1975 and 1985 and comments by Lord Owen about the destruction of papers from his private office at the time."

Then if we go further down the page, please, Henry, we see in paragraph 5 it refers to a review that had been undertaken. It says that that was not set up to address Lord Owen's comments about his papers from his period as a minister being pulped. Then it says this:

"Unfortunately none of the key submissions to ministers about self-sufficiency from the 70s/early 80s appear to have survived. A search of relevant surviving files from the time failed to find any."

Then there's a suggestion:

"One explanation for this is that papers marked for Public Interest Immunity during the discovery process on the HIV litigation have since been destroyed in a clear-out by SOL. This would have happened at some time in the mid-1990s."

A. Well, it was obviously a mistake that this was included in the letter.

Q. It was a mistake that you saw this memo?

A. This document, yes. It was -- that wasn't meant to be sent to me. That was a briefing for him to send the reply to me. So then we realised that something more was going on.

Q. In terms of your own direct knowledge, do you know any more about what happened to any of your papers?

A. No.

Q. Now it's right to note that we've been provided with statements from Lord Hunt and Lord Crisp by the Government legal department which respond to various observations in your statement. I'm not going to take time now in going through the paragraphs of their statements but they will, in accordance with the Inquiry's normal procedures, be disclosed and placed on the Inquiry's website as a response to criticisms made in your statement. But I don't know whether there's anything further you wanted to say, Lord Owen, on the specific issue of destruction of documents?

A. No. I've read it, but I don't wish to make any comment. I think it's over to you, is the answer to that.

Q. Lord Owen, I wanted to, finally, ask you, before we

break and others have the opportunity to suggest any further questions, I want to just ask you about a speech you made in Parliament in November 1989.

You've exhibited it again, I think, to your witness statement. It's LDOW0000349. We can see the date, 23 November 1989, debate on the address, and we see that your contribution starts at the bottom of the page, but if we could go on to the next page please.

SIR BRIAN LANGSTAFF: Is this going to be relatively short, Ms Richards?

MS RICHARDS: Yes, it is.

We can see, if we pick it up in the bottom half of the page, left-hand column, you refer there to the infection of 1,200 haemophiliacs with HIV and then the very bottom of the page you say:

"I feel personally responsible."

You refer to your announcement in January 1975. And then if we can just go to the next column, you set out the pledge that you made. You say -- you repeated it, and then you refer to what was then said in 1982. Then you have said this:

"I have tried to persuade the Parliamentary Ombudsman to investigate this issue but failed. If ever there has been a clear and graphic case of maladministration, this must be it."

Then you say this:

"We are all responsible."

I just wanted to ask you, Lord Owen, what you meant by that statement, "We are all responsible"?

A. Well, when a policy is announced to the House of Commons by the Government of the day it becomes the responsibility of the House of Commons. The whole point of trying to commit a Parliamentary democracy is that you can examine the policies of the Government. Many of them are not important and don't carry, you know, they are not what you would call a policy, they are a reaction to circumstances.

But why do you -- why, as you see it today, the Speaker is very keen that ministers, even prime ministers, make statements to the House of Commons not to the press, and the whole issue is that that's where your democracy is debated. That's where you are held to account by your peers.

So when you make a statement to the House of Commons and, in my case, repeated statements about a policy, it is the possession of the House and if you now change it you should tell them. At least that's my interpretation of the democratic processes. You know perfectly well we don't have an unwritten constitution, so everybody has their own view, but

that has been broadly the view upheld by successive Speakers and if you want to change the policy, then you come and tell the House of Commons you have changed it, if you have announced it to the House of Commons, in that sense they possess it.

MS RICHARDS: Thank you.

Sir, is that a convenient moment for our next break?

SIR BRIAN LANGSTAFF: Yes, it is. I think you have more or less finished the questions you have to ask except for those that may be suggested to you by others.

MS RICHARDS: Yes, this is an opportunity during the break for those who represent core participants to suggest any further questions and then, after that, for Lord Owen to make any final observations that he wishes to make.

A. I will be very brief. I have said all I need to say already.

SIR BRIAN LANGSTAFF: It has been a long day but we will detain you just a little bit longer if we may?

A. Fine.

SIR BRIAN LANGSTAFF: Can we come back aiming for 4.00. You may need more time. If you do you let us know and we will let you know, Lord Owen. It will be 4.00 or shortly after. So, 4 o'clock.

(3.16 pm)

(A short break)

(4.00 pm)

MS RICHARDS: Lord Owen, there are various disparate questions that I've been asked to ask of you so the next few questions are going to dot around from topic to topic.

Could we have up on screen, please -- and this is your testimony to the Archer inquiry -- LDOW0000345, please, Henry. If you could go to page 28.

Page before that, please. Thank you.

So if we see at the top of the page, this in the context of the Chair having asked you some questions about the Medicines Act. You say at the top of the page:

"I was actually the sponsoring minister for the pharmaceutical industry in those days, it was later taken away, and it was a very good relationship, in fact, so good that I argued inside the Government and got permission for one moment to use the Medicines Act to deal with smoking but it was eventually dropped."

And then you are asked about whether the final say was with the committee and you said:

"Yes, the Secretary of State would be advised by

the committee. The politicians would not get involved in that."

The question is what being sponsoring minister for the pharmaceutical industry actually entailed.

A. It was responsible for trying to develop into a world-beating, international, research-orientated manufacturing industry which would earn money for Britain and attract high quality scientists to this country and research groups into this country.

It involved at one stage, for myself, talking to Merck Sharp & Dohme and getting them to site a research group here in the UK -- it's since left -- but it was above all trying to be a centre of excellence, building on the database particularly of the National Health Service which was available and still is available and is still used for clinical trials and ground-breaking research.

It's not an accident that we have two major world-class pharmaceutical companies, GSK and AstraZeneca, here in the UK. And I think that we have to earn our living in the markets of the world and I think we are in a position, because of the National Health Service and the knowledge base that it gives us, to continue to be a centre of excellence in medical and pharmaceutical research.

Q. Did your role as sponsoring minister for the pharmaceutical industry affect at all your approach to applications such as that by Armour that we saw in the documentation?

A. Not at all. I don't think -- as I explained, a company who wants to sell their products in this country, first of all, has to go to what was then the Medicines Commission and others to get the say-so that it's of a quality that is sufficient, and those are pretty far-reaching tests. So the medical profession has to be satisfied that the product is -- what it says on the label is true and also that it's safe.

In my case, I'm not quite sure or -- and I think I've said that in evidence -- quite why it was coming to me other than it was a hot potato and they might have wanted me to know that this application was being made and what extent we would take account of the fact that they were coming in at a lower price.

I wouldn't normally get involved in any price decisions. I was surprised when I read the piece of paper. I'd forgotten the meeting. But I think it was because it was politically sensitive and maybe they had asked, "What are the prospects for us?" And that's why I specifically told them about our commitment to the World Health Organisation's policy.

Sorry I can't more helpful. But I don't think it conflicted at all.

Q. Then you've made clear in your evidence your concerns over blood safety. You've referred to Titmuss and indeed the material that you would read in the BMJ and The Lancet and so on.

As far as you are aware, were your concerns over safety shared by the doctors and civil servants within the Department who were administering policies on a day-to-day basis?

A. I think when -- I mean, self-sufficiency had been discussed well before I came into the Department and, you rightly pointed out, going back into the 1960s. I think we all have to recognise that.

I think once I'd made the decision, the Department rallied behind it completely.

I mean, I loved being in the Department. I found it a stimulating place, people were not afraid to disagree with you and to debate and argue with you, but if you made up your mind and you knew what you wanted to do, I think they were loyal and very committed to seeing that the policy that you were advocating was introduced.

Q. Did anyone ever express to you within the Department a different view about safety than the view that

you've articulated?

A. On safety?

Q. On safety. On the risk of blood and blood products?

A. If they expressed a view on safety, that was a professional judgment, which is not for me. I had to abandon being a doctor at that moment. I wasn't there to challenge their view. If they had a view on safety, that prevailed.

Q. Can you recall -- and again, I'm acutely conscious of the fact I'm asking you about events a long time ago -- can you recall if there were discussions within the Department which others within the Department expressed a different view about the safety concerns than the view that you've expressed? Did they say that safety issues weren't important, for example, or that there wasn't a significant risk from blood or blood products?

A. I don't remember anybody coming to me and saying, "We should ban supplies coming in from overseas". Because that issue was well ventilated, and discussed quite frequently, in the professional advisory bodies that had been set up by the Chief Medical Officer. And I was well aware of them but, I mean, we know them. I mean, they are, you know, what would be the consequences of not having doctors with what they

thought was the right treatment for their patients, and who they discuss with their patients and they wanted them to be, whether it was in particular AHG concentrate. So I think that's the fundamental thing.

Cryoprecipitate we could always get from our Blood Transfusion Service. We needed -- so I think that was the main one and I've discussed it very openly, all the dilemmas of that. But those issues were put to the specialist committee.

I mean, you know, we haven't actually mentioned it but the Guardian ran a story about the 1983 decision which went to the committee on safety in drugs -- I didn't mention it -- about whether they should stop importing blood because of HIV. Again, that decision was: we should continue; the problems are there but not having this facility would be more damaging.

You see, a lot of these decisions are decisions of shades of grey. They are not often black and white decisions. Remember, medicine is a biological science. It's not -- they are not quite so clear-cut as some of the other scientific decisions if for no other reason you're dealing with human beings and behaviour is there. It is a perfectly legitimate view and it was frequently discussed and in the

professional bodies and under two successive Chief Medical Officers of Health, George Godber and Henry Yellowlees, whether or not you should stop. They never advised ministers that that should be done.

If they had done so it would have been followed because on this they are basically sovereign. You might have argued with them but I wouldn't have done and I don't think any of my predecessors or successors would have done. This was a decision of the medical profession.

Then when they saw the possibility of self-sufficiency, most doctors grasped it, wanted it, and that was the case for the Blood Transfusion Centres, by and large.

Q. Were you ever during your time as Minister asked to make any resources available for research into any forms of viral inactivation; so heat treatment or other methods of making product safe? Was that something that you were ever asked to consider?

A. Not to my knowledge but, again, that would be funded usually by research programmes which, broadly speaking, were -- there was a chief scientist attached to the Department, a very eminent and extremely able doctor and scientist, and he chaired the committee of where the Government's research project. The

Department of Health was a sponsor of research in academia and in clinical trials and a whole range of things.

I think we were all the time looking for ways in which we could detect hepatitis in blood supplies and a great deal of research was done, and I gave you this memo which the -- which I found in my papers but is in your official papers of Henry Yellowlees sending a "Dear Doctor" letter dealing with this issue of how you deal with the discrepancy of blood donors coming from certain countries where hepatitis was of epidemic proportions, and how to deal with this complex issue and to deal with it sensitively and, since it could have been associated to colour, to getting a sort of semi-scientific way of looking at this.

So I don't think -- this is different, the Department of Health, from Department of Education or something like that. I wasn't ever in the Department of Education. It's more analogous to being Minister for the Navy where you do give a special regard to and independent view to the admirals and the generals and the air martials and you do the same in the Department of Health to doctors and scientists. I think the ministers who are much more prone in those two departments to be guided by the professional advice,

they find that's not just the right case to do but almost the moral case to do.

You have to trust professionals.

Q. Did you know anything, in terms of the UK's own blood donation system, of the practice of taking blood from prisoners in the United Kingdom? Is that something you were ever asked to consider?

A. Yes. Funnily enough, that "Dear Doctor" letter deals with the question of whether you should stop donations from prisoners. There's a paragraph of it. So perhaps you would circulate that document.

Q. Yes, in fact, we're going to be looking at it tomorrow.

A. Okay.

Q. But you were aware that blood was taken from prisoners?

A. Yes. They looked at that professionally and to see whether it was -- and he deals with that in a paragraph on the second page.

Q. Did it occur to you to take any steps to intervene to stop that practice?

A. No. I've tried to make you accept that these are professional judgments, you know. You wouldn't -- if the Chief of Defence Staff who is trying to co-ordinate all the views across it comes and argues

for a particular weapon system over another, your bias or your pre-disposition is to accept their professional advice. You're not a soldier, seaman or airman. You may query the cost. You may query that it's not as high priority as some other weapon system, is it, but if they held to their ground, you tend to go with it. I mean, I don't think we should be too ashamed of saying that.

On the other hand, you exercise your political judgment to question them about their priorities and question their advice and ask them for the evidence for their advice. It's a difficult question of how the lay person deals with professional advice when it's highly specialised on science.

Q. Then, Lord Owen, in your witness statement -- Henry, sorry, it is WITN0663001, paragraph 15 -- so page 6, paragraph 15 -- page 6, please.

The previous page, sorry.

Thank you. So in paragraph 15 you say this:

"What doctors were advised to say to patients was the responsibility of the then Chief Medical Officer ... Dr Henry Yellowlees. I had the greatest confidence in his expert knowledge of public health and it was certainly not for me to intervene in that professional relationship from the CMO, having

consulted specialists, to the medical profession. At all times, I encouraged the greatest possible transparency between the large haemophiliac community, their organisations and the Department."

There are two questions I have been asked to ask arising out of that. The first is, in terms of the statement at the end, that you encourage the greatest possible transparency between the community organisations and the Department, the question is how you did that. What steps were taken as far as you can recall?

A. Yes.

Q. What steps were taken by you to encourage that transparency?

A. Well, I remember asking how often they were in contact with The Haemophilia Society. I would ask how much they were trying to share their experience of -- within these committees. I did look carefully at the advisory membership of committees, where the people came from, was there a balance of professionals. You didn't want only haemophiliac experts, for example, or AIDS experts, you wanted well-grounded scientific opinion. It wasn't for me to choose the people but it was for me to make sure the advice was broadly based and not only dominated by London teaching hospitals,

for example. Where it is much easier if you pull them in from London, you know.

So they consult the Royal College of Physicians. There's a constant linkage between the Royal Colleges, and I think this is a good structure that we have in Britain, and I do remember once going to the Royal Colleges and saying, "You've got too close to the Government", and they should value their independence. And Government will always try and bribe them off with good grants and everything like that, and that's the nature of the beast. The politician will try to gather consensus around him. The Royal Colleges have to be very careful about keeping their independence, and they are not answerable to anybody other than their professional body.

I mean, I'm a fellow of the Royal College of Physicians, and I'm proud of that and proud of the College, but sometimes they get over-wooed by Government.

Q. The second question arising out of paragraph 15 that I'm asked to raise with you, Lord Owen is this: given what you've said about the serious risk of infection from contaminated blood, why did the Department not make any public statement about the extent of that risk to inform patients? Why did the Department leave

it to individual doctors to tell their individual patients?

A. It's a very good question and maybe one the Inquiry wants to look at. Is there too much freedom given to the profession and should we be more ready to give advice from the Department which is effectively an instruction? You would meet huge resistance. I mean, after all, why was the medical profession and the BMA against the creation of the National Health Service initially? Because they feared that Aneurin Bevan would start to run the health service and tell them what to do and doctors would lose their independence.

It was always bogus but it was used -- and is still used in America, they call it "socialised medicine", and they say that -- actually, I personally argue with many of my American friends, and my wife is American, that there is more freedom within the British National Health Service for clinical freedom than there is in an insurance-based health system, as you have in America, which actually is much tougher in holding doctors to routines and structures and this sort of thing.

So you gain something, you lose something, but -- you know, I'm hopelessly prejudiced about this, of course. I watched my father as a general

practitioner, I watched him from a very small boy. I used to go out in the car with him to keep him company when he went out to Dartmoor and some remote farm. When I was a medical student, I would go into the farmer's house with him; he'd always go first and ask for permission and he would teach me medicine in his own way. We'd come to usually the same diagnosis but somewhat different routes because of our age differences.

I'm an utterly committed supporter of the National Health Service. I am totally opposed to the marketisation of the Health Service. You know, I believe in it. And I don't believe you could have a British National Health Service if you had done what the scaremongers said, that you would have politicians running the Health Service, politicians telling you what medicines you can or cannot have, if you were telling -- politicians refusing to let doctors argue for an expensive treatment.

This dialogue that exists in the British system and the trust that people have built up that they are not going to be told by the politicians what their medical treatment -- broadly speaking in the National Health Service we have this thing called NICE, which is to try to evaluate the cost-effectiveness of

medicine, but it's, broadly speaking, guidance. Sometimes it does say you can't do this treatment. It's often very controversial when they do it. They have that well regarded scientific assessment, fairly recent in the National Health Service. I think it's hated by the pharmaceutical companies around the world but, broadly speaking, I think it has got the right balance of trying to draw attention to doctors that they are making -- the average general practitioner is making decisions every year in the millions, quarter of a million -- or consultant. You know, you are making very expensive decisions. And everybody needs to be cost conscious. You can't refuse to face up to the consequential effects of spending huge sums on very expensive cancer therapy at the moment.

Does this answer the question?

Q. I think I asked you a wide question and you've explained your thinking.

There are then a couple of specific questions relating to Wales and to Northern Ireland that I've been asked to raise with you.

The Welsh and Northern Irish Chief Medical Officers, did they report to you and to the Secretary of State or did they report to the Secretary of States for the particular regions?

A. It was, I think -- we asked that earlier. It was devolved to some extent but there were some groups where the scientific advice to the Chief Medical Officer gave advice also to Wales and to Northern Ireland. A little less so from Scotland because the scientific -- as I told you, they have their own Scottish Royal College of Physicians and their own Scottish Royal College of Surgeons, they have a larger number of medical schools and universities, so that Scotland is more self-sufficient, if you might say, in terms of medical advice and things like that, and more traditionally independent, way before all the current debates about independence and other things.

Northern Ireland, as I said, varied, because it -- some time during this period it was under direct rule.

Q. I think for the whole of the period with which you are concerned.

A. Yes. So that would be the Secretary of State for Northern Ireland would take decisions but be hugely influenced by -- they would tend never to go against the grain of decisions that were taken in England. But they had the freedom to do so if they wished to, and they had to take account, you know, of border questions and what was happening in Dublin. And,

again, it was good relations. All the time I was in office with the Republic on healthcare matters I can't remember ever any difference of opinion.

Q. You said in your earlier evidence that it was, in principle, possible for the Chief Medical Officer, and you were here dealing with the Chief Medical Officer for England, to issue some form of directive or guidance that overrode the views of regional medical officers or doctors.

Did the Welsh or Northern Irish Chief Medical Officers have the same ability, as far as you know, in exceptional cases or otherwise to issue such directions or instructions?

A. Yes, I think they did. There would be some -- I mean, you're seeing it on your screens every day, you know, more or less, in COVID. The Chief Medical Officer is making his views very clear, and the politicians broadly speaking are listening to him, and quite rightly so. But he's balanced by the Chief Scientist, who happens to be a medical doctor but it wouldn't necessarily be the case that the Chief Scientist would be a medical doctor. So there have been cases which the Chief Scientist was not a medical doctor but would still be involved in advising the Government on the science.

And you are all beginning to understand, I think, you know, the science is a tricky issue. What is the truth? And the statisticians are needed and -- so it's -- I'm sure the CMO can say to various of the bodies that are advisory, "I am afraid I disagree with you."

Q. In the event that the Chief Medical Officer for whichever nation did that, intervened on questions relating to clinical matters or safety, would you, as Minister, or whoever the Minister was, nonetheless retain political responsibility for those decisions?

A. Yes. You could disagree with the Chief Medical Officer for Health if you wanted to and -- you see, a lot of these relationships are he comes to you to convince him of something he wants to do. You listen carefully, you question him, and then you decide to accept his advice.

In that conversation, you can raise objections and he would say, "Well, I'll go and think about this", or, "I'll go and discuss it with colleagues again". It's more consensual, the political relationship. Everybody's different.

Government departments are all different. The Foreign Office is notorious for having a view of foreign policy itself and they don't like it if the

Foreign Secretary disagrees with them. I mean, I disagreed with them about quite a number of issues. That was difficult because they didn't have the same -- it's quite a different tradition the Foreign Office and the Ministry of Defence and the Ministry of Health. At the end of the day, the senior officials can always go up through the diplomatic service to the Prime Minister direct or through the Civil Service Commission to the departmental head and to the Prime Minister direct.

Q. In terms of your self-sufficiency pledge in January 1975, was that a pledge that covered Scotland, Wales and Northern Ireland as well as England?

A. In effect, yes. In practical terms, yes. In pedant's arguments, no. Scotland could have appealed to the Secretary of State for Scotland and I think I did say it wouldn't come to me, it would be brought up directly with Barbara Castle and they could take it to Cabinet.

So the Secretary of State for Wales, the Secretary of State for Scotland and the Secretary of State for Northern Ireland had the right certainly to challenge a Ministry of Health decision for England but in those days it was more ready to accept it and in the powers given to, in a pandemic, then you use

emergency powers and the powers of co-ordination are stronger.

But devolution has given Wales and Scotland more independence and they do have their own Chief Medical Officers advising the First Minister of Scotland and the First Minister of Wales. But you can see that they are trying hard I think to try to reach agreement in COBRA and other things on COVID. We make a notice, there's a certain licence for the Chief Minister in Scotland to make a little adjustment, you know, and people sort of say ... but they're broadly speaking. The Chief Medical Officer of Health constantly says on television that there are really no differences between the different Chief Medical Officers in Wales, Scotland, Northern Ireland and himself, and I think that is a good sign and it's a sign that the professions are trying very hard to work together in a pandemic.

Q. During the time you were Minister, the Secretary of State for Northern Ireland was I understand Merlyn Rees MP?

A. Yes.

Q. Do you recall whether you ever had any meetings or discussions with him about the issues of self-sufficiency and blood contamination?

A. No, and Merlyn was a friend and I knew him as a colleague in the House. We worked very well together when he was Home Secretary and I was Foreign Secretary. He wouldn't have hesitated to tap me on the shoulder as we were going through the division lobby and say, "David, you're saying this and my people are saying something different". That's one of the advantages of the collegiate nature of the House of Commons is that you are seeing each other. You actually, as long as, I hope, good sense prevails and you go physically through the division lobbies and not tap in your yes or your no or your aye or your nay in a computer. This brings you all together quite frequently and a huge amount of business is done in the division lobby.

Q. We've seen from some of the documents we have looked at and we obviously haven't looked at them all, records of meetings where there is certainly a representative from Scotland present, from the SHHD. To what extent, as far as you're aware, were there meetings on this specific issue, self-sufficiency, blood safety, factor concentrates, with any officials from the Welsh or Northern Irish equivalents?

A. Well, I was going to mention it that I constantly mentioned, because I think it was such an important

paper, Cash's BMJ article, which is very critical of the defencing and I kept saying 1980. It actually was published in 1987 so I would like to get that, if I could, the record corrected on that.

I personally think it's a very good thing that Scotland has a distinctive say and always has. I'm a unionist. I believe in the union but I'm a strong believer in devolution, I always have been. So I have no problem with the present constitutional settlement. In fact, I would go for making the nations a little bit more defined in the constitution and their rights. I think that's the next logical step to go after Brexit, to have a more federal structure, personally.

So I don't -- I mean, look at the benefit. One benefit we have is Scotland has been more generous to the sufferers of haemophilia and AIDS than England, Wales or Northern Ireland.

Q. Just dealing specifically with Northern Ireland and Wales in the 1974 to 1976 period --

A. I think it was much more collegiate, much more wanting to be together, and there was none of this posturing of separation. I mean, I use my words deliberately. There's a lot of posturing. And I think it's not helpful but there we are, that's life; you have to live with it.

Q. Do you know whether consideration was ever given to sending plasma collected in Wales to the PFC, the fractionation centre in Edinburgh, for processing? Were there ever any discussions that you were privy to about Wales and Scotland establishing a relationship in the way that we know that Scotland and Northern Ireland did?

A. I would encourage more discussions. Remember, these professional bodies, they're all treating haemophilia. They usually have conferences annually, sometimes more or less. They have trained -- you can train the Scotland and practice all your life in England or vice versa. They know each other. That's why it's so important that the advisory board that the Chief Medical Officer in England sets up should be broadly based. And I think that applies to everything.

Q. There are just three further questions from core participants, Lord Owen.

The first is this: did the dire financial situation -- that's the language of the question -- did the financial situation in the 1970s, including the 1976 IMF bail-out, impact upon funding decisions to achieve self-sufficiency?

A. Yes. The first two years under Barbara Castle -- and, you know, I pay tribute to her, she was a fantastic

boss. We often had quite considerable differences in the different political positions inside the Labour Party but we practically never had any really major disputes, and I found her a stimulating leader and somebody who liked discussion and, indeed, some disagreement. So no problems at all about that whole structure.

I've lost a bit the conversation -- the question again, if you could come back to me?

Q. The specific question you answered with a single word I think. It was about the financial situation in the mid-1970s.

A. Yes, it was huge. I mean, look, we had the IMF to satisfy. That happened after I was in Government. I was in the Foreign Office by the time the IMF discussions had come but we had to pull back on public expenditure. And then we had devaluation, in which the value of the pound goes down in everybody's pocket. And so we all felt the pinch. So all through this difficult time you had to weigh very hard the difficulty.

I mean, when on your film the gentleman from Northumberland -- or was it --

Q. Dr Peter Jones, Newcastle.

A. Yes -- wanted 20, whatever it is, million -- or was it

more than 20 million? I mean, I just smiled, you know. I wanted 20 million more! We all wanted, for everything. You have to choose, and of course it is difficult.

But we did it. This is what is important to keep remembering. The Department made their observations, I made the decision, they loyally followed it, they chased, they guarded, they put it in things, and that limited amount of money achieved a substantial way towards self-sufficiency. It didn't achieve it but, against a rising trend of demand, it overachieved what we expected.

So I don't think there is any reason for anybody who was involved in the Department during that period to hang their head in shame about this at all.

Q. I've been asked to raise with you an observation you made about Lord Hunt. You said in your earlier evidence that what Lord Hunt said about self-sufficiency being driven by cost --

A. No --

Q. -- was a blatant lie?

A. -- if I may interrupt, I didn't say he said it. It was in the briefing document which he published, and it's a -- there were some bull points. It was the second bull point. He never said it. And to all

great credit. I haven't read every word he has said in the House of Lords debate but I don't think he used that bull point. And I hope he didn't. But that was what I worried about.

Which did that come from? Was that a political appointee putting up a sort of party political stuff, you know? And -- well, then it's understandable. It wasn't clear.

If it was that, well, that's just part of it, party political badinage. But if it was the Department thinking that, then that was very worrying because it was manifestly not true.

Q. We will try and check the reference then and see if I need to check up on that.

A. Lord Hunt to the best of my knowledge did not say that.

Q. Thank you. Then a question which I'm asked to ask you, and I want to get the way in which it is put as precisely as I have been asked to put it.

Is the evidence which you have given to the Inquiry restricted to any extent by the fact of you being a privy counsellor or by any obligations under the Official Secrets Act or is your ability to give a full and frank account of your knowledge about matters falling within the Inquiry's terms of

reference restricted in any other way?

A. None at all. I don't believe that I feel I would say anything any different -- anyhow, I've sworn the oath, which would override all of these except for the Official Secrets Act, and the Official Secrets Act, there's nothing. You never see in the Department of Health a classified document which -- you know, "UK eyes only" or something like that. You see the whole time when you are in the Ministry of Defence and Foreign Affairs but no, no, never really.

There are very few things -- very few things -- you can't be open about. We weren't open about the first case of -- I've got a blank. What's the illness that's all over Africa? Ebola. Yes, the first case of Ebola came in and the Chief Medical Officer came in himself, shut the door behind him, and my private secretary was not at the meeting, and he told me that we were having a plane flying in with a case of Ebola, and this is how he wanted to handle it. And it was to send it straight down to Porton Down, which then was a Ministry of Defence establishment, it's no longer that, and was dealing with research into chemical weapons, and had the facilities to completely isolate the patient and to deal with very, very high quality level of treatment, and I said yes.

We, I think, kept this quiet for a while until it was clear that we were able to handle the whole thing but that was a very serious medical emergency and we were both of us very frightened that it would somehow break out, whether in the airport or on the way down. Once they were there we were completely confident they would confine it and contain it. That was the most secret, if you like, thing I think I ever had when I was Minister of Health.

We kept it very tight as the number of people who knew about it.

Q. I've been asked to return to one question and answer that you gave in this current session. I had asked you the question about why the Department didn't take any steps to publicise the risk to patients, why it was left to doctors, and I think you talked about the issues of clinical freedom.

A. I don't agree with that. Didn't take any steps to publicise it? I mean --

Q. Forgive me, carry on.

A. Document after document poured out for the medical profession, for nurses, there was no secret in medical education, medical students were taught about the side effects of all these things. Articles were written. I went myself on World in Action. I answered

questions in the House of Commons but also on the BBC.

I don't think I ever used -- where you have to be a little bit careful in what you say is the fear factor and that's a real problem. You know, and I do believe that must be for the doctors to say what are the side effects of drugs, not so much for the politicians, because they can put it in context to their patient and that's why, and I'm sure there are many haemophiliacs who will tell you that their doctor wouldn't move them off cryoprecipitate into AHG concentrate and it did cause a little bit of tension between them.

They were advised to be careful about this and if they were mild symptoms and we did try and deal with the donor size. I've dealt with all of this but I'm just trying to say I understand this feeling, you know, particularly a young child who then in adulthood realises that they were exposed to these things feels anger, resentment.

I really understand it and I wish one could find an alternative way of doing it but in the end of the day it's either the general practitioner, the one-on-one relationship in the family, or with these very high quality advisers on haemophilia. Sometimes the GP will say it is the job of the specialist. I've

given it to the specialist. The specialist is the person who is -- they are up-to-date. They know all the different things and where treatment is coming from.

Now, sometimes perhaps that was not told and I'm sure there are people, I hope not too many, but people who genuinely were never told at any level. I understand why young children were not told. That was up to the parents. But if they were of age then they should have been told and the parents should have been told and I'm sure the medical profession failed them a little on this as we as politicians have failed them.

We have to face up to it. We did not achieve self-sufficiency. I did not achieve self-sufficiency. I deeply regret that and I don't think the politicians can walk away from this or the medical profession can walk away with it. But it was very difficult to achieve, but we were warned and the facts were out there, and the medical profession, you produce very good evidence that they -- the Chief Medical Officer, Godber, had the facts and, you know, books were published. Titmuss did his bit, the television programmes.

There was no, as far as I really know, I don't

believe there was a climate of secrecy about this in any way inside the Department of Health. It was just felt that the way you would tell people would depend on what their condition was, how mild was the dosages, how bad were they affected?

Q. Is this correct, leaving aside, you've rightly pointed to your interview on the World in Action, which could be said to be a statement to the public, it's a public television broadcast, leaving aside that, the Department's position was that the question of what doctors told patients about the risk of blood products was a matter for the patient doctor relationship and the Department did not -- I say leaving aside any television broadcasts -- itself take any steps to either tell doctors what they should say to patients or provide information directly to patients?

A. Correct. The Department does not interfere with a doctor-patient relationship. The Chief Medical Officer writes to doctors. The Chief Medical Officer appoints advisory committees. The Chief Medical Officer has constant flow of information coming from the professional Royal Colleges and everything else. But the Department does not decide the treatment of a patient. That is done through the medical profession, and that is what we call clinical freedom,

and that is much prized and I would be very, very, very worried about a politician who wanted to change that relationship.

As I say, that was the smear against Aneurin Bevan. That was what was the argument that this is what would -- socialised medicine was going to ... and, as I told you, I think there's more freedom inside socialised medicine, if you still call the NHS a socialised model, of which I have some considerable doubt personally.

I wouldn't will that on you, that politicians start getting involved in medical treatment. This may be a sign of failure, it may not work wonderfully well, but I can assure you a hell of a lot more grievous mistakes would be made if politicians started deciding on treatment.

Q. Lord Owen, before I ask you if there's anything else you want to add I will just turn my back and see whether there is anything else anyone is pressing me to raise.

I'm happy to say nobody else.

Lord Owen, those are my questions for you. It may be that Sir Brian has some questions for you and I think you wanted to add something at the end.

Questioned by SIR BRIAN LANGSTAFF

SIR BRIAN LANGSTAFF: Yes, just a few questions, if I may. I don't want to keep you there any longer than is necessary.

A. I am totally at your disposal.

SIR BRIAN LANGSTAFF: Thank you very much.

As a matter of principle, do you see it as one of the first duties of the state to look after the safety of its population?

A. Yes.

Q. So that would extend to the safety of patients receiving blood or blood products?

A. Yes.

Q. You said in part of your evidence this morning something which I pricked my ears up at. It was in the context of your advocating something like the New Zealand system of no fault compensation and you said this:

"... we've got to stop relying on governments to make awards or judgments of liability and inadequate payments after years of pressure in Parliament and all this and go for the New Zealand system, with no fault compensation, and take it out of law courts and take it out of all this confrontational system and accept that in healthcare we sometimes damage patients. Not willingly, not wantingly sometimes out of ignorance,

sometimes ..."

And this is the part I want to ask you about:

"... sometimes out of, in this case, deliberate decision."

So you see it as a deliberate decision that was taken by someone, or some system, that had the effect of hurting patients?

A. I think the financial limitation on the Health Service -- I mean, you can't be Minister of Health for very long without realising that ideally you would have very substantially more money to spend. And it is interesting that the United States spends a great deal more than we do on healthcare. I mean, it's up in the 15-16 per cent of GDP, and some people say it's even higher. Do they achieve a very much better overall healthcare system? I think most people think not, and most international comparisons think not. And for a long time the British Health Service was thought worldwide to provide the best of healthcare and the most cost-effective.

I don't think we can make some of those claims as easily now as we could have done 15 or -- when I was Minister of Health. I think that was the report of the Commonwealth Fund that used to look at international comparisons. We came out very, very,

very highly. We did neglect cancer care for quite a while, and our figures were poor compared with quite a lot of other European countries. They have improved recently.

So I think that financially we do make decisions as politicians in the overall allocation to the Department of Health, and we could argue you should spend a lot more on health, and I've spent quite a lot of my time arguing that. And I would go to the meetings with the Chief Secretary of the Treasury asking for more money every single year when I was there. And I'd come back in the first year very pleased, and then the second year less so, and the third part of the third year not at all happy about the amount of money that I was able to spend then within it.

So it is effectively a rationed system. I used the word "rationed" and people objected. Barbara Castle took me in and was rather angry with me. Three weeks later she was using the term herself with relish. It's the only way of explaining it. You can't pay for everything.

SIR BRIAN LANGSTAFF: So just help me, if one were to ask what was the deliberate decision that damaged patients in this case, what would you say?

A. Well, I think that you could ideally have made the decision a lot earlier to go for self-sufficiency. We knew about the contamination of blood supplies. We did know about hepatitis. We didn't recognise AIDS for quite a while but in '82, from '82 onwards, it was recognised, and blood transfusions still went on.

SIR BRIAN LANGSTAFF: So the deliberate decision is really a failure to decide to go for or ensure self-sufficiency earlier?

A. I think we must all take -- politicians must take collective responsibility, and I take my share of it. I went into Parliament in 1966 and we ought to have recognised the consequences for the Blood Transfusion Service. It should have been an issue a lot earlier, you know. And an awful lot of people didn't know Titmuss' book, and a lot of people didn't know until they watched two programmes about these issues, so ...

We're seeing this over COVID, you know. Did we spend enough on preventative health and did we have efficient enough track and trace system in record already on there? Preventative health, the problems we hear about a track and trace now are all there in the public expenditure cuts of successive governments on preventative health and local public health. You don't have to look very far for that and no doubt

eventually we will face up to that truth.

We did publish, in Barbara Castle and my time, a pamphlet, a little booklet really, "Prevention ... Everybody's Business" it was called. And I think we do neglect prevention, because the drama is associated with renal transplant or cardiac replacement or some of the brilliant surgeries going on, robotics and everything like this, and London teaching hospitals take a very large percentage -- at one time, less so now.

So the allocation of money is, you could say, a moral question.

SIR BRIAN LANGSTAFF: Just on the money side, can I understand better what the arrangements were in particular with Elstree? Let me tell you why I ask. My understanding, but it may be wrong, you may correct me, is that in the 1970s, until 1977, Elstree was run by the Lister Institute, which was not an arm of Government, it was not a commercial pharmaceutical company but it was an institute which had two limbs to it. One, for many years it had been engaged in research, privately funded for that purpose, I think it may have come about because of TB and polio some years -- at the end of Victorian era, start of the Edwardian, but it was beginning to run out of money,

as I understand it, in 1970, and rapidly so with the increase in inflation.

Is that about right?

A. Yes.

SIR BRIAN LANGSTAFF: So it would have had no money for its second arm, which was research.

A. I didn't catch the last sentence.

SIR BRIAN LANGSTAFF: It would have had less money to spend on its second limb of its activities, which would have been research.

A. I think it was a mistake for it to be run by the Lister Institute. I think it was a mistake not to take it into a very different structure.

SIR BRIAN LANGSTAFF: But at the time you were Minister of Health, and until I think it was 1977 when it became the joint responsibility of the DHSS and the North West Thames National Health Authority, the Blood Products Laboratory, though part of the National Blood Service, wasn't centrally funded.

A. Quite right.

SIR BRIAN LANGSTAFF: So the production of NHS, as we call it, factor concentrate by BPL --

A. The region was acting for the NHS a whole, if you like. That was quite a common pattern. You gave to a Regional Health Authority a national provision --

I can't think of other things but I think there are more examples of that. You see the executive arm of the Health Service were the Regional Health Authorities in England with a great deal of independence.

SIR BRIAN LANGSTAFF: Well, I was going to ask you about that because the way in which blood transfusion worked was it was, as far as England and Wales were concerned, was a question for the local regional health area.

A. Yes.

SIR BRIAN LANGSTAFF: The regional transfusion centre, and so they could have different policies.

A. Mm-hm.

SIR BRIAN LANGSTAFF: They could defer different donors or accept different donors.

A. Yes.

SIR BRIAN LANGSTAFF: And it was funded out of the Regional Health Authority budget, wasn't it?

A. Yes.

SIR BRIAN LANGSTAFF: That budget would have to spend money on what you've described I think already as other challenges of health, but perhaps the more obvious ones, the cardiovascular, the problems which people had orthopaedically, diabetes, cancer, the big

health issues as they may have seemed at the time. To fund a central laboratory for supplying or to a state where it could supply factor concentrate to the whole country would have demanded some top slicing of their cash.

A. Yes.

Q. I imagine there might have been reluctance about that.

A. Well, you have to remember that the election took place and the first and only issue for Barbara Castle, and I hadn't even been announced to be appointed Minister of Health, and she said, "David, stay, I would like you to hear this conversation", and the Permanent Secretary to the Department came in and said, "Mrs Castle, I want to say to you one thing: I'm going to pose you a question about whether or not you will carry out the McKinsey's massive transformation of the Health Service under Sir Keith Joseph and we are going to argue that you should let it go and not follow your manifesto commitment to make changes. But if you decide to do it and to not take our advice we will loyally follow what your decision is".

Here was this, people think of a dogmatic, Mrs Thatcher's equivalent on the left, if you like, and with some justice really, abrasive and confident and she listened to all these very powerful arguments

against making a change when only in a few weeks' time was the appointed day when the new Sir Keith Joseph thing was unravelled and they explained at every stage what were the problems and, of course, the role of the regional and the area health authority and everything like that was all redefined in this district three-tier structure.

She listened to all these questions and then she turned to me and, as I say, I wasn't even appointed, she said, "David, well what do you think?" I must say I took my courage in both hands because I wasn't at all sure which way she was going to come down and I said, "Well, you know, we fought an election on a manifesto which is to change the structure but we're being told here by objective evidence that if we start tinkering with the system the whole thing will collapse, it just won't be able to take it, and I think they are right". She said, "I agree with you". I was staggered.

But from that moment on we accepted that structure and I think this is one of the real problems for politicians, is you go on tinkering with the machine or when do you say you can do this safely because almost all of these reconstructions and re-organisations take time to settle down.

So we, effectively, accepted, with some minor changes to making the consumer health councils slightly more democratic, we accepted the structure and that's the political system we live with and not -- it's quite unusual for somebody to show as much pragmatism as Barbara Castle did in that decision, helped by the fact that she had already served in Government from '64 and learnt a lot and been a good minister and a good executive actually.

But that was the problem that we -- hung over us, and throughout this decision -- as I tell you, I referred to Abel-Smith at one time, the whole structure, we were on a very difficult line of being very careful about making these changes in the situation that maybe we should have done, you know, a decision which I never asked for, and I don't want to make this decision and Barbara Castle -- I took the decision too -- this is too fragile to go and have a massive reconstruction.

Now this wouldn't have been a massive one, but taking it away from the regional health, which then was an acceptable system for the others because they would trust that particular regional chairman to consult them a good deal on the Blood Transfusion Service, I ruled it out basically. We were living

with a period in which we were not going to make big structural changes, we were going to sit through it. Then, as the economic crisis deepened, we became more and more convinced that that had been the right decision. As I say, it was not mine, it was Barbara's, but I thought it was a very courageous decision for her to make.

SIR BRIAN LANGSTAFF: Under the structure as you had it and the structure that you weren't going to tinker with, am I right in thinking there would have been two possible routes for providing funds to develop and improve the facilities at Elstree, assuming that you could provide that money to what was then a private institute, the Lister? One would have been direct payment out of central funds; the other would have been to ask the regions to contribute an aliquot so that together they could have the advantages of having a BPL supply them all?

A. Yes, it would have been possible.

SIR BRIAN LANGSTAFF: And the second of those two would have involved quite a lot of horse trading, I imagine, on a political type of level -- I don't know, you tell me -- with the regions to extract the necessary money.

A. To put it into a completely private commercial arrangement, give it to a company you mean?

SIR BRIAN LANGSTAFF: Well, to give it to the Lister.
A. Give it to?
SIR BRIAN LANGSTAFF: The Lister Institute, to fund BPL.
A. Well, I don't think that was -- been the right place for it. If you were going to do a major reconstruction, I think you could have -- I think given -- it is true to say that I've spent very little time on that issue at all. I knew that it was wrong and that it would have to be looked at, and I was against quite a lot of these executive powers that continued to be maintained by the regions when you'd created this new area. So we had districts, areas and regions, and we kept in my view a ridiculously large number of powers for the regions. And I was a totally opposed to that. But that would have been immediately seen as dismantling the regional structure if you had done that. So you would have gone into a hell of a row about that.

By and large -- I mean, I had not much business experience but I had spent two years, not very widely known, but working for an MIT company on structural changes in business under a professor of marketing called Arnold Amstas, who was a very brilliant man, who formed his own company. So I was not completely inexperienced in that, and I had also spent time

running the dockyards as Minister of Health, which had an industrial labour -- as Minister of the Navy -- of over 60,000, and closing one of them too. And it was dealing with the Whitley Council and everything. So I'm not totally -- and I wasn't hostile to the idea of different structures, but I think that things were very fragile. We only had a very small majority and -- we barely had a majority. So all of this would have meant unpicking the Keith Joseph legislation. I think the legislative committee would have told you this isn't a priority.

So if the electorate decides to give a Government only, you know, a limited -- by '66 we'd won the election and had got more of a majority but -- I'm trying to wonder the whole election schedule. In that election, it was -- '66 was in the summer, wasn't it? And we came in with a big majority, that's right. We could have done it I suppose. But another reorganisation of the National Health Service? Cabinet would have had to agree, the legislative committee would have to agree. I don't think they would have given us the time of day, but ...
SIR BRIAN LANGSTAFF: Could you --
A. I mean, I understand why, looking at it now, objectively, the structure was wrong. Of that I have

no doubt and you may be right, and I'm sure you'll say so if you come to that conclusion, but I'm trying to give you the picture of why it was more or less ruled out because of the Keith Joseph reorganisation.
SIR BRIAN LANGSTAFF: On the same general theme, I'm sorry if we haven't got a copy -- if Henry doesn't have available DHSC0100024_126, but this is 27 July 1974, and it's a BMJ editorial, and it's about the blood donors and transfusion service.

While Henry is looking -- I'm sorry, normally counsel gives these references in advance. I didn't know until listening to you that I was going to ask --
A. Should it come up?
SIR BRIAN LANGSTAFF: You have got it, have you? No. But essentially it was an editorial that argued that the Blood Transfusion Service was ill-equipped to do the job as a modern transfusion service, and amongst other things it suggested that the shortage, as it called it, of blood, allowing entries to the pharmaceutical companies, was not a real one but a consequence of poor administration, organisation and underfunding. Do you have a view on that? You must have read it at the time.
A. I agree with it, and I think it was quite inappropriate to be put into a Regional Health

Authority who, personally, I think should have been more or less demolished as part of the restructure and it should have been areas and a stronger department. So I would have found no difficulty -- and I don't actually think I would have found too much difficulty in asking a major pharmaceutical company to do it as an agency arrangement for the Government.

I think -- I hold strong views about the marketisation of the National Health Service but I don't want the National Health Service to become a pharmaceutical company. And I wanted competition amongst pharmaceutical companies. And I think that was an essential fact in trying to keep prices down. So I have no wish within a National Health Service to have a hostile attitude to the private sector working in partnership with the British National Health Service, and there's certain areas which I think you are not involved in.

I was worried about creating a company like we did with BPL on blood transfusion, privatising that and selling it to Bain because you were not giving it to a pharmaceutical company like GlaxoSmithKline or AstraZeneca. It has a permanent presence in the pharmaceutical industry. Bain is a venture capitalist, effectively.

Now, we sold it but now where it is -- you know, our blood in this country at the moment comes from the United States and the United States is picking quarrels with lots of countries outside, you know. You've lost control of a very important element, so if you were going to privatise I would have chosen a British company and I would have chosen one with expertise and that would be the pharmaceutical company.

Now, it is interesting at that particular time I did have a businessman who came from Burroughs Wellcome who was advising me, and the first question almost when I became Minister was the same Permanent Secretary who said to Barbara Castle, came to see me and said, "I thought you would probably want him to leave". I said, "What makes you think that?" He said, "Oh well ..." I said, "I want the best advice on the pharmaceutical industry I can and if he ran Burroughs Wellcome and he's ready to come and work for me I'm only too happy for him to stay".

So I do think, in my case particularly it's not motivated by what can or cannot be done by the private sector. It was a decision to try to go for self-sufficiency as quickly as possible and not to get saddled with a whole legislative argument and

a business of saying that you were trying to get rid of the regions, you were trying to change the Sir Keith Joseph reform and you were running against McKinsey.

If McKinsey's were so bright why didn't they as part of their restructuring with the Blood Transfusion Service. They spent a couple of years and vast sums of money. This was no time for a Minister of Health, particularly a junior one like me, to take on the whole of this issue of restructuring regions which is what was involved with taking it away from it? They would never have believed us if we had said, "Oh, we're not really after it". They would see it as an attack on the Regional Health Authorities, which we had already said we didn't like.

SIR BRIAN LANGSTAFF: Can I change tack just a little. It's a linked area, perhaps, but it arises out of this. Back in 1952 on 21 July there was a WHO (World Health Organisation) report. If there is a reference I'm not sure if it is available, but it's RLIT0000215, but essentially part of it dealt with the question of how to minimise the risks of serum hepatitis and it came up with five basic principles, five things that might be done.

Now, the first of those was donor selection and

you've dealt with that in your evidence. You've described how one would select the voluntary un-remunerated blood donor in preference to the paid donor for the reasons you've explained and you would not wish to have anyone who had ever been yellow or jaundiced.

The second was pool size?

A. Sorry?

SIR BRIAN LANGSTAFF: Pool size.

A. Yes, pool, yes.

SIR BRIAN LANGSTAFF: You have indicated that that was something well on your radar and that of the Department in the '70s when you were Minister and you would see an advantage in keeping the pool size as small as possible presumably.

Did you happen to know, did any your advisers know what the difference was between the NHS pool size and that from the commercial concentrates which were being imported?

A. Yes, I think there was a paper which I found only a few nights ago which does look at this issue in really quite a lot of detail and depth, and I wasn't sure where it had come from and I wasn't sure whether I'd read it, but it was in my papers. But it was -- I don't know is the answer but I know that there was

a comparison of commercial blood and it went into, I think into pool size comparisons. I can't remember the figures.

SIR BRIAN LANGSTAFF: Did you have any sense about the relative sizes that one was smaller than the other?

A. My hunch would be, given my general disrespect for the Blood Transfusion Service, that the pool size was larger but I don't know.

SIR BRIAN LANGSTAFF: The third matter which the WHO drew attention to as a safety measure, was taking steps to inactivate the virus or to treat the plasma. That I suspect might have involved research.

A. This is the '52 document.

SIR BRIAN LANGSTAFF: The '52 document, and obviously the principles followed through, but in the 1970s was, to your knowledge, any research being done on how to treat plasma to reduce the risks of serum hepatitis?

A. I can't remember. I think ...

There was a lot of research. There was some German research on this. I don't know what was done in Britain. It's the sort of field which would not be so much the Chief Medical Officer but Douglas Black, who was the Chief Scientist, ought to have been involved in that area. He was very good, a quality scientist. I don't know whether he -- but, you know,

he knew all about the problems we were dealing with of self-sufficiency. He was perfectly within his remit to come up with this. You can't know everything yourself but the appointment of a Chief Scientist was I think a fairly recent one. It was a good one actually. The Chief Medical Officer of Health. Medicine is not the same discipline as a scientist and Douglas Black was a very high quality.

SIR BRIAN LANGSTAFF: I don't want to put words into your mouth at all but do I take it from your last answer that you can't recall, specifically anyway, any particular allocation of funds or effort in the Department to researching how best to --

A. Well, the Department does very little of that type of research. It isn't a research department.

SIR BRIAN LANGSTAFF: No, but it could finance it and arrange it, couldn't it?

A. It could help finance. Most of that was done by the Department of Education, as the sort of science related to the universities. Wellcome was not, of course, as strong as it is now, which takes a huge amount of medical research out of Government but on a sort of charitable basis.

I don't think much research would have been generated by the regions, that's for sure.

SIR BRIAN LANGSTAFF: That was going to be my next question. I think you have given what -- from your earlier answer, what might be --

A. It was completely the wrong place for it. It was an agency for the rest of them and it encouraged them all to believe that they were not part of a National Health Service, a national transfusion service and were individual regional fiefdoms. But they did take some authority from the nominal region that was in charge of it but I mean it was not -- it was still very resistant. You can see it in the papers. I mean, they were resistant to ideas, resistant to the Department coming in, and when we made the decision for self-sufficiency, the Department officials and John Reid, the Deputy Chief Medical Officer, was treading on, you know, hot rocks really, had to go and persuade. They dealt with the regions through persuasion rather than through executive decision.

I mean, at this time we made the decision to put all the new money that was decided, as a result of the Butler Report, for regional security units, and new money was found and given to the regions and it's one of the biggest scandals: they spent practically none of the money on the regional security.

So this was already an element in which you saw

that the regions just did what they wanted. They took from Central Government, very difficult money to find, to introduce the Butler Report on regional security units -- because Broadmoor used to be under us as well as all this -- and they never spent it on it.

Parliament was thoroughly critical of the whole thing. So they were very powerful figures, the regional chairmen, and the permanent secretary was in constant dialogue and discussion with them and so was the Chief Medical Officer for Health, and it was beneath -- they didn't really -- answerable to the minister very much.

SIR BRIAN LANGSTAFF: Thank you very much.

The only other thing I wanted to ask you was this. You said at one stage in your evidence that if we had achieved self-sufficiency then the supply of factor concentrates from America would have been stopped.

Would that have been a formal stopping through the Medicines Act process or not?

A. Well, they were contractual, so you saw that in the Armour -- you had a decision to take whether they would be given the contract. I presume that by warning them that we were going to abide by the WHO resolutions that you were telling them, effectively,

"Your contract could be curtailed". Now I didn't look at the contract, I'm sure, but I imagine that, subsequent to warning them, they would make some provision in the contract for termination or they would make the contract for -- well, not for 20 years or -- you know ...

You know that you make decisions and expect, then, certain consequences to flow from them. So if you tell Armour that that is -- you expect then the contract division to take some account of it.

Now maybe they didn't. Maybe I should have followed up on that to find out whether they did or didn't, but I was -- there is no doubt we would have cancelled the contract, but at that stage it would have been a sensible decision to make sure that the contract wasn't going for too long otherwise the compensation would be considerable. That was presumably my intention when I said them, was to reduce the -- I mean, you were into a commercial relationship and I imagine and hope that they were given no long-term contract.

SIR BRIAN LANGSTAFF: In terms of clinical freedom that would then have operated if the contract had been cancelled, would a doctor, let's say a purchasing haematologist in one of the regions, or his regional

manager making a purchasing decision, would they still have remained free to buy commercial concentrate but in reality would never have done so because they would have to find the money from somewhere and the region wouldn't give it?

A. Well, the implication in one of the papers that we've actually had before us today -- I can't remember exactly -- it implies that they were doing just that, that they were -- considered that they were independent over this.

I mean, I didn't consider that but in the area we were in, in which had not yet been proven what we could do, that was a fight for another day, but I think that -- I definitely think they think they did have that freedom.

SIR BRIAN LANGSTAFF: It's really a question of how far clinical freedom goes when somebody else controls the purse strings.

A. Yes. And that's the way you control the regions, was the allocation of money.

Now, at this very moment I'm having a fight with the thing called the Resource Allocation Working Party. I came in with a prejudice maybe -- but pretty good evidence for it -- that the four London regions were taking far too much of the overall budget and we

had to change the allocation system.

Again, you know, we were not -- we didn't have a large majority, and so I took the decision that we would introduce an objective system for allocation of resources based on deprivation statistics, and we set up the Resource Allocation Working Party.

Now, technically I could have said this is the allocation but all hell would have broken loose and I had to devise a formula which would be acceptable and scientifically based.

There was a very able civil servant at that time called Smith who oversaw that process, produced a report, gathered a good deal of sympathy and understanding for the mechanisms of which of the resource allocation working party and we were all set to make an allocation based on that, and then there was an election and it was not taken.

But you went through a long process then and it took two to three years to build a consensus that the allocations to the regions would be based on different criteria and it would mean slowly moving resources from London out into the provinces. I'm a provincial figure. I was born in my constituency in Plymouth and so I was no doubt looking after my own but it was actually an objective attempt to try to allocate

resources on the basis of evidence and not on the basis of prejudice or political persuasion.

SIR BRIAN LANGSTAFF: Can I --

A. All I'm trying to indicate is once again you were trying to take a decision with a longer timescale and a fraught political situation. We did not like the McKinsey recommendations, we did not like the Keith Joseph reforms, but we decided that we would live with it.

SIR BRIAN LANGSTAFF: Can I -- I have finished with my questions. I am afraid have detained you there far too long and I am sorry for those who are waiting.

A. You are the Chairman of this Inquiry you are entitled to ask for as long as you like.

SIR BRIAN LANGSTAFF: Maybe, but I may have overdone it so my apologies if I have.

A. No.

SIR BRIAN LANGSTAFF: Can I just thank you hugely for coming. It's always difficult to sit in the witness chair, particularly as I made clear this morning in these times when there are risks attached which go beyond the usual, and you are the first and it's always difficult to be the first of a number of witnesses other than those who have been directly infected or affected by what took place.

So on both those counts you deserve our gratitude. But, more than that, you have given us an insight I think into the way in which politics controlled the Department of Health and worked, at least in your time. You've demonstrated the pressures and reminded us of what Bevan had to say about them and you haven't shirked the acceptance of responsibility individually, collectively, for -- amongst politicians and Parliament for what took place or didn't take place and that is brave and thank you for that. You've given us a lot to think about.

You have also given a commercial for Titmuss' book and can I just say for anyone who wants to answer the commercial by going out and buying a copy, there are two versions both of which I've read actually, one of which is the old edition and one of which is a revised modern edition. It's the old edition you want if you ever do want to go and buy it and chapter 8 is the chapter which Ms Richards focused on and I think is the right chapter to focus on for us in this Inquiry. But there we are.

MS RICHARDS: Sir, I should just say I was going to ask Lord Owen the now standard question of whether there was anything that he wanted to add following the questions that he's answered.

A. I will try to be very brief. Firstly, I would like to make a correction in my own written evidence on page 18, paragraph 46. I refer to John Morris that's a mistake. It should be Alf Morris. I've already paid a tribute to Alf Morris.

A lot of people out there are responsible for this Inquiry and not many of them are politicians but there were some outstanding people and Peter Archer devoting his time as a former Attorney General to hold the Archer Inquiry was I think important, particularly for the morale of those people outside who were all the time campaigning for this Inquiry.

We should be humble enough to admit as politicians that this Inquiry was not taking place because of a conscious decision to do so. Successive governments, Labour, Conservative and Liberal Conservative coalition governments all refused it. It was eventually done because there was a Parliamentary majority that was going to vote it through and the Government had no option.

So we have, all of us politicians, failed to face up to the fundamental thing: when things go wrong, be prepared to have a post-mortem. The medical profession has its failings but it does actually try to systematically look at its mistakes, particularly

when the patient is dead, and try to see if they could have done better.

We need to look at how to do better. And I would just say positively, I hope very much as a result of this Inquiry there is some changes made. I've indicated where I hope they will come. You mentioned the New Zealand no fault compensation. There have been some proper serious studies of it recently, particularly in Scotland. I refer to that in my commission. I recommend it to people who are trying to look at ways of -- compatible with the National Health Service, which it looks as if we are going to go on having, and I bless that factor.

Then the other question is the Ombudsman. I so think such a vast organisation as this has got to have another mechanism than the Parliamentary debating one, and I hope the Ombudsman would be a success. I think it has not been a success, and I think that -- Parliament and particularly you I hope will look at it and make recommendations, because I think you would be very influential on all of those things.

I have already referred to my mistake in referring to John Cash's demolition article really on the Blood Transfusion Service in the BMJ. I often said it was 1980, it was actually '87, so I keep to

that.

So I end, finally, with a word of thanks for all those people who we had long debates with in The Haemophiliac Society, haemophilia sufferers, AIDS sufferers, the families, the people who have devoted a huge amount of time. I could name them all. One person who even went and got self-educated and wrote an MSC on the whole issue of this, and it's still a big resource document for us. A lot of people who have made this Inquiry possible, a great many hopes and aspirations lie that we will -- but above all, we politicians and we doctors -- I am a member of both, I still believe both are honourable professions -- must ask ourselves many questions and look at many of our own internal procedures to try to make sure that this sort of mistake doesn't happen again.

SIR BRIAN LANGSTAFF: Thank you very much indeed.

MS RICHARDS: Sir, there are no further questions.

SIR BRIAN LANGSTAFF: Thank you, Ms Richards.

Tomorrow, 10 o'clock?

MS RICHARDS: Yes, sir.

SIR BRIAN LANGSTAFF: What do we have tomorrow?

MS RICHARDS: Tomorrow is a presentation on the developing public medical and scientific knowledge of the risk of infection from blood and blood products.

SIR BRIAN LANGSTAFF: Ladies and gentlemen, Lord Owen, stay safe. I will see those of you coming back tomorrow.

(5.30 pm)

(Adjourned until 10.00 am the following day)

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